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Vol. XXXVIII JULY, 1951 No. 1

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Volume XXXVIII **JULY, 1951** **No. 1**

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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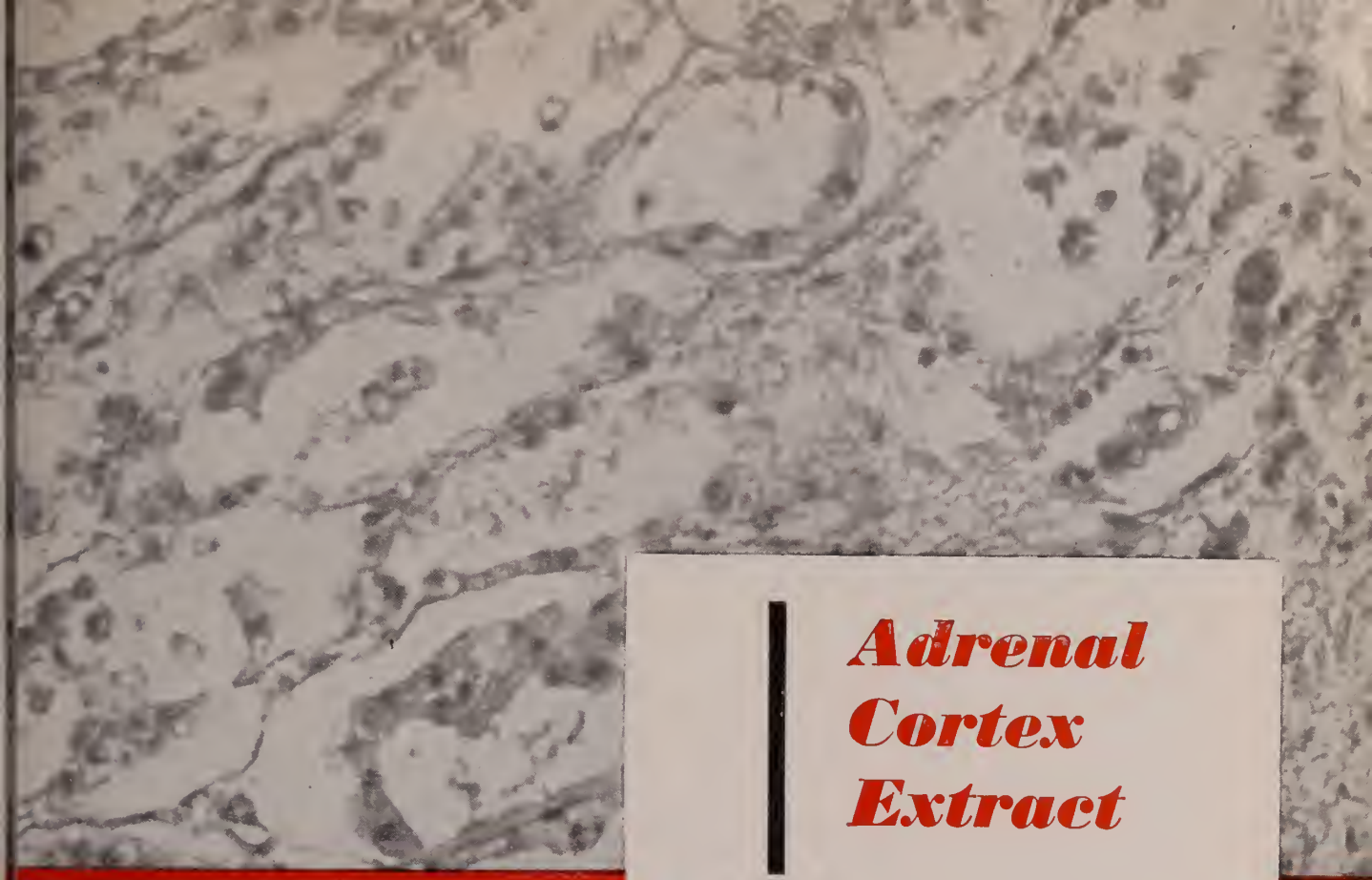
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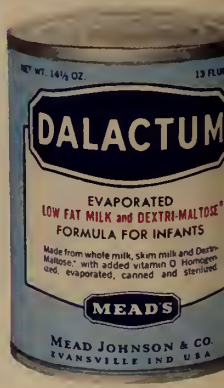
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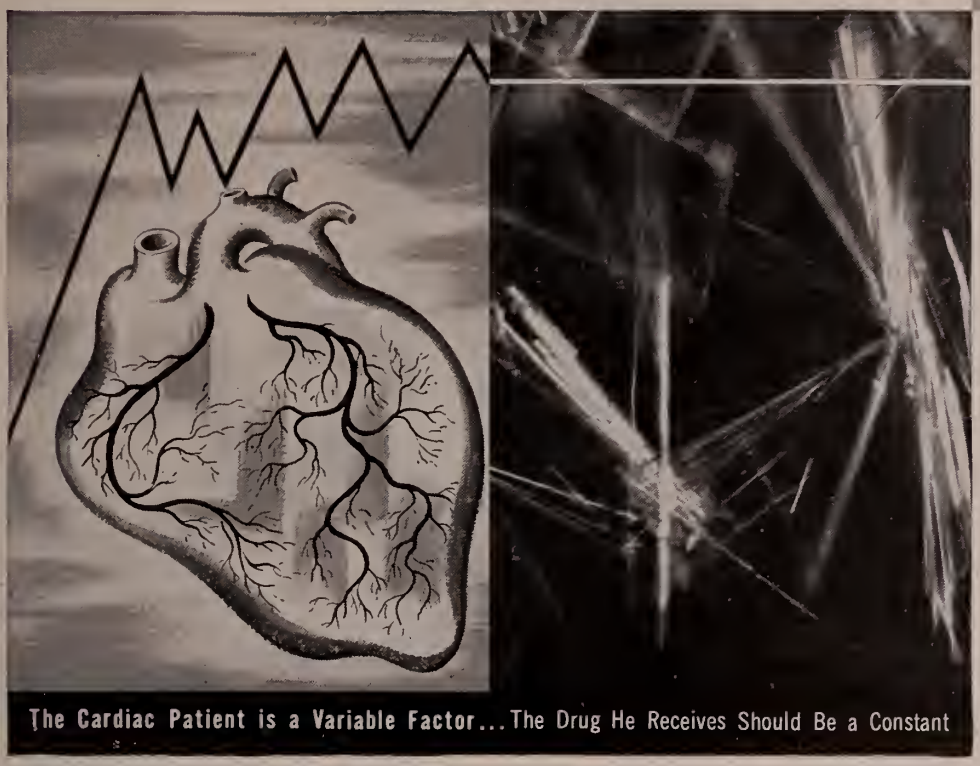
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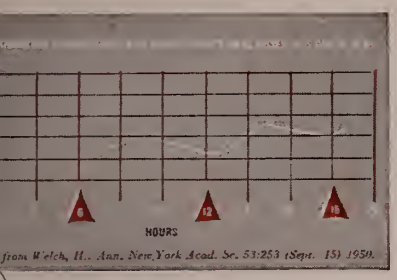
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXVIII Jacksonville, Florida, July, 1951 No. 1

Massive Resection of the Small Intestine Follow-Up Study of a Case After Removal of Twelve Feet Six Inches of Small Intestine

JULIEN C. PATE, M.D.
AND
JULIEN C. PATE, JR., M.D.
TAMPA

It is naturally with some trepidation that the surgeon undertakes massive resection of the small intestine. In this emergency there is, in addition to the operative recovery of a critically ill patient, the vital consideration of maintaining thereafter both nutrition and reasonable bowel function. The lack of general agreement as to the amount of small intestine which may be resected with satisfactory recovery has doubtless prevented removal of many lesions involving large portions of the small intestine which might have been resected successfully. The purpose of this paper is to present after ten years a follow-up study of a case[1] in which 12 feet 6 inches of small intestine was resected.

Length of Resected Intestine

The removal of 7 feet or more constitutes massive resection. Although the length of the small intestine has been variously estimated and undoubtedly varies considerably with the individual, 200 cm. is generally conceded to approximate one third of the total length. Cattell[2] recently concluded that removal of this amount results in little change of intestinal function if there is no interference with the blood supply of the remaining portion of the bowel, but he added that removal of larger portions increases the operative risk to a considerable degree. He regarded the preservation of sufficient arterial supply to nourish the remaining portions properly as the greatest problem at operation.

In the series of 257 cases collected by Haymond[3] in 1935, the length of resected intestine varied from 200 to 299 cm. in 143 cases to 800 cm. in 1 case. The mortality rate was comparable in any length from 200 to 499 cm., and in general the results became poorer as the amount of intestine removed became longer. Included in this collection is the unusual case reported by Sarnoff[4] in 1923 in which, after perforation of the uterus by a curet, there followed prolapse of the intestine through the inch-long opening; resection of 15 feet of small intestine with hysterectomy, complicated by partial obstruction and fecal fistula, resulted in recovery.

Among additions to the literature since Haymond's comprehensive survey in 1935 is the case reported by Cattell[2] representing the most extensive resection performed at the Lahey Clinic. In this case the patient was a 70 year old white woman who recovered completely following removal of all of the small intestine except the upper 3½ feet of jejunum, the right colon and a third of the transverse colon. Reporting survival of a patient after removal of 20 feet of intestine, Holman[5] related that he "measured the small intestine removed against the side of a three-foot sink, much as a draper measures ribbon and found there was 19 feet of small intestine, as well as the caecum, ascending colon and some of the transverse colon."

In the case reported by Bowen,[6] an estimated 10 to 12 feet of small intestine was removed from a child aged 9 years. Elman and Read[7] reported a case in which but 3 feet of jejunum and half of the large intestine remained after several operations. In 1 of 2 cases with recovery reported by

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 23, 1951.

Coleman and Bennett,[8] the specimen removed measured almost 7 feet; in the other case, one of severe shotgun wound of the abdomen, the resected intestine measured 14 feet 8 inches with 22 inches of colon, a total of 440 cm. Prioleau[9] reported 2 cases, in the first of which the specimen removed consisted of 260 cm. of gangrenous small intestine, with its mesentery, and two segments of gangrenous colon, measuring 19 and 12.5 cm., respectively; in the second, 354 cm. of gangrenous small intestine and 40 cm. of large intestine were removed.

Period of Survival

In 116 of the cases in Haymond's series the period of survival was recorded. Patients living one year postoperatively numbered 15; two years, 11; three years, 10; four years, 3; five years, 1; six years, 2; seven years, 2; eight years, 1; ten years, 1; eleven years, 1; fourteen years, 1; and 18 years, 2. Cattell's patient was well three years after operation. Holman's patient, who had previously undergone abdominal hysterectomy and later removal of the breast for carcinoma, not only made a good recovery following resection of 20 feet of intestine for volvulus but one year later "weighed a little more than before her operation" and "was actively engaged in parish work as a clergyman's wife." Over a period of five and a half years the child operated on by Bowen[6] had developed normally.

In Prioleau's first case the patient was in normal health three years following resection of approximately 40 per cent of the small intestine with a section of sigmoid colon, and two subsequent major operations for re-establishing intestinal continuity. In contrast, the patient in the second case survived removal of approximately 53 per cent of the small intestine and a section of large bowel, but pursued a generally downhill course, living only four months. In the case of intussusception reported by Coleman and Bennett,[8] the patient had remained well three years. In their case of severe shotgun wound, the patient two years later was in an excellent state of nutrition and was able to do the heavy work of a fisherman. In our case, the patient has remained in good health for more than ten years, a period longer than reported in the literature reviewed except for 4 cases in Haymond's collection.

There follows a summary of the case[1] reported in 1942 with subsequent data added.

Report of Case

W. R., a white farmer, aged 36, married, was admitted to the Tampa Municipal Hospital on Nov. 6, 1941, complaining of severe epigastric pain. There was a history of gastric disturbances for approximately fifteen years and an operation for perforating peptic ulcer two years prior to admission, with chronic dyspepsia in the interim.

At 4 a.m. on the morning of admission, four hours before hospitalization, he had been awakened by a knifelike pain in the upper portion of the epigastrium beneath the tip of the ensiform cartilage. He had fallen unconscious and had been found in a convulsive seizure. Upon regaining consciousness and drinking a small amount of milk, which had often relieved the dyspepsia in the past, he had experienced increasingly severe pain and had vomited for an hour with the pain unrelieved.

On admission, the patient was suffering agonizing cramplike pain in the epigastric region, the one outstanding indication of acute illness. The temperature was 96.8 F., the pulse rate was 54, and the respiratory rate was 16. The blood pressure was 126 systolic and 88 diastolic. Peristaltic sounds could be heard. A tentative diagnosis of perforating peptic ulcer was made.

Sedation in the form of 1/6 grain of morphine and 1/150 grain of atropine was administered at 8:35 a.m., and upon arrival in the operating room the patient was so comfortable, with the abdomen flat and soft and the pulse strong, that the operation was deferred. This state would indicate to the observer a gradual rather than a sudden vascular occlusion was taking place. Severe epigastric pain recurred at 3 p.m., eleven hours after the onset. One-sixth grain of morphine was again administered. At this time the temperature was 97.8 F., the pulse rate 64, and the respiratory rate 22. When aroused at 6:30 p.m., he was in no pain, but some tympanites below the umbilicus was now noted for the first time, and only an occasional tinkling was audible upon auscultation of the abdomen.

Roentgen examination of the abdomen for free aid and fluid levels gave negative results, as did urinalysis. Examination of the blood at 10 a.m. showed hemoglobin 58 per cent, erythrocytes 3,400,000, leukocytes 9,800, polymorphonuclears 88 and lymphocytes 12 with the nuclear index 8 and the color index 0.9. At 7 p.m. the hemoglobin was 78 per cent, and the count was erythrocytes 4,100,000, leukocytes 25,400, polymorphonuclears 93 and lymphocytes 7 with the nuclear index 5 and the color index 0.9. Although a necrotic process was undoubtedly present, there were no clinical symptoms to indicate its location.

At 7 p.m. the patient suddenly began to show signs of shock, and when he reached the operating room at 9:30 p.m. his condition was poor. The blood pressure was 80 systolic and 60 diastolic, and the respiratory rate was 20.

At operation, about 100 cc. of serosanguineous fluid was present in the peritoneal cavity. A large mass of small intestine, dark black in color, was encountered, and the mesentery supplying this strangulated portion of intestine was likewise black and was pulseless, its appearance resembling that observed in mesenteric thrombosis. A large rent in the mesentery had contracted, strangulating 12 feet 6 inches (375 cm.) of jejunum and ileum. The usual procedure of determining bowel viability was carried out. After the necrotic portion of the bowel was resected, only 12 inches of the jejunum remained. The patient left the operating room in fair condition.

The pathologic report, submitted by Dr. H. R. Mills, follows:

"The specimen . . . consists of about 375 cm. (12 feet 6 inches) of small intestine which shows marked passive congestion with the exception of about 15 cm. of healthy tissue at each end of the specimen. Opinion: passive congestion and necrosis of small intestine."

The end to end anastomosis proved satisfactory as no fecal fistula developed. There was no evidence of obstruction postoperatively. Wangensteen suction was continued for five days, during which time an infusion of 1,000 cc. of a 5 per cent solution of dextrose in normal

saline was given every eight hours. On the fourteenth postoperative day the patient was discharged from the hospital in good condition, his only complaint during the entire postoperative period having been slight weakness.

Four weeks after discharge he reported no discomfort and no dyspepsia since the operation. He was having one bowel movement daily and had gained 11 pounds in weight. On April 4, 1942, five months postoperatively, he had gained 20 pounds, felt better than for fifteen years and was having normal elimination daily. His appetite was excellent, he stated, and he ate anything he pleased from cabbage and pork chops to sweet potato pie. He was engaged in farm work, plowing and digging fence posts without experiencing inconvenience.

He has been followed now for more than ten years. On request, he submitted to roentgen examination on Nov. 24, 1947. The report of the roentgenologist, Dr. A. F. Massaro, follows:

"Examination of the gastrointestinal tract after ingestion of a barium meal:

"The stomach is of average size and shape. It shows normal tone and peristalsis.

"Duodenum: The duodenal bulb is normal in size, shape and position.

"There is an absence of some of the loops of the jejunum. The loops of the ileum have a normal appearance. The cecum and ascending colon have a normal appearance.

"Findings: There is a decrease in the loops of the jejunum in the left, middle and lower quadrants. The loops of the small intestine that are visualized have a normal appearance. The barium goes through the small intestine at about the normal rate."

Ten years have now elapsed since the emergency operation, and the patient has remained in excellent health the entire time. He has continued to engage in heavy farm work.

Discussion

The amount of small intestine removed, the disease condition necessitating resection and the general health of the patient are all factors in prognosis. With some apparent exceptions, the nutritional status is definitely affected by the relative amount of bowel removed. From the literature it would appear, discounting the operative risk and postoperative complications, that a patient may be expected to regain a normal nutritional status following the removal of 33 per cent of the small intestine and that 50 per cent is the upper limit of safety in extensive enterectomy although with resection of even more the result in the exceptional case may be better than may reasonably be expected.[3,9] Accordingly, it would appear that in our case the outcome was particularly fortunate since more than half of the small intestine was resected.

Loss of weight, anemia, diarrhea and at times edema result from inadequate compensatory changes. The rapid passage of intestinal contents may cause great change in bowel function, even producing serious and intractable diarrhea, which in turn causes excessive loss of blood electrolytes and interference with proper nutrition. Three to five watery or semiformed stools daily, which are not uncommon, may usually be reduced to two or three a day after several months with adherence to proper diet.[2]

Excessive loss of fat and protein in the stools and low blood calcium and serum proteins are characteristic. In their study of digestion and absorption in a patient who retained but 3 feet of small intestine as a result of five resections in eleven years, West, Montague and Judy[10] found assimilation of carbohydrate normal. About 25 per cent of the ingested protein and 45 per cent of the fat, representing roughly 25 per cent of the calorific value of the ingested food, were lost in the feces. The large proportion of free fatty acids in the fecal fat indicated fairly satisfactory digestion of fat and poor absorption of fatty acids. Poor calcium absorption was probably explained by the large amount of fatty acids in the feces, for the daily ratio of fecal calcium to fecal fat was remarkably constant. Their recommendation of high carbohydrate, adequate protein, low fat diet with additional calcium and vitamin D is in line with the observation of others.

The normal elimination and normal nutritional status established immediately following operation with prompt gain in weight and the continued absence of nutritional disturbance over a period of more than ten years in our case is noteworthy, especially so since the patient has in no way restricted his diet. In the case reported by Elman and Read[7] in which so much diseased intestine had been excised in a series of operations that only 3 feet of jejunum and half of the large intestine remained, the patient gained 50 pounds in weight with practically no difficulty in digestive function within six months after the last operation, was enjoying an unrestricted diet and was having but two semisolid stools a day. They associated this remarkable physiologic feat with compensatory mechanisms that must have developed during the years in which more and more of the small intestine was removed. In the case studied by West, Montague and Judy,[10] following several resections over a period of years the dilatation and hypertrophy of the remaining 3 feet of small intestine were regarded as compensatory to its shortness. Cattell's elderly patient, with a like amount of functioning small intestine, was reported free of digestive symptoms and enjoying a normal diet without restrictions after the last operation although vitamin therapy was continued.

Summary

A case of massive resection of the small intestine reported in 1942 is reviewed and additional data added. Despite the loss of 12 feet 6 inches of small bowel, the patient has remained in normal health on an unrestricted diet for more than ten years.

The length of resected intestine, as recorded in the literature, the period of survival and the late effects of resection on the heroic scale are discussed.

When the surgeon at the time of laparotomy is confronted with the serious problem of resection of the small intestine, experience in this case and in others cited from the literature may encourage him to expect better results in some cases than may seem warranted.

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Discussion

DR. EDWARD JELKS, Jacksonville: Dr. Pate's report of removing successfully more than one half of the small intestine and his studies of the patient since the operation introduce the subject of small bowel function, especially in relation to surgical conditions.

Soon after the brilliant work of Pasteur and master bacteriologists who followed him, the etiology of most diseases was thought to be the effect bacteria have upon tissues, either by direct attack of cells or by influence of cell action by toxins they produce. Some of you who were trained before the first World War were taught this theory of the cause of disease. Naturally, on such a theory there developed the idea of focus of infection with metastatic spread from the local to distant areas.

Recently, in addition to these ideas, and in some instances substituting them, the physiologicochemical point of view has been stressed to explain pathologic changes in the body. In the removal of the major part of the ileum, Dr. Pate, while saving the patient's life, has performed an experiment of removing a part of the body whose function is necessary for preventing starvation. In his discussion he stated that most patients, after loss of the larger part of the small intestine, do not live longer than a few months or years. They starve to death. When the major part of the small bowel is absent after surgical excision, or its function is destroyed, the patient loses weight, his metabolism becomes lower, and in the blood changes occur in the content of various products which are the same as those present when the patient is denied food. In both instances, should food be eaten, there is not sufficient small bowel function for the digestion and absorption necessary for nourishment of the body.

This lack brings to mind another interesting surgical problem, namely, that of gastrocolic fistula following ulceration of a gastroenterostomy stoma. Here the function of the small bowel is thrown out of commission by regurgitation of colic content through the stoma. When this occurs, there develops a physical and symptomatic state almost exactly that seen in starvation from lack of food or removal of the small bowel. In gastrocolic fistula the infection of the small bowel secondary to regurgitation from the colon is sufficient to destroy mucosal function and bring about the state of starvation. Sometimes almost unbelievable relief of the patient's symptoms and general condition is gained by the making of a colostomy proximal to the fistula whereby the contents of the tract are prevented from entering the distal colon to infect the mucosa of the small bowel by regurgitation. Whatever jejunitis and ileitis may be present clear up immediately.

It seems logical that starvation in a like manner plays a most important role in certain types of bacterial infection of the small bowel. It is life-saving, therefore, to supply the body parenterally with the products of digestion when the apparatus for producing and absorbing them is temporarily not functioning.

After excision such as Dr. Pate reports, it is interesting to observe that changes in the patient's physiologic state resemble closely those in which the function of the small bowel is diminished by mucosal changes and to find in both instances the many resemblances to starvation. Perhaps this concept of the manner in which changes in the small bowel cause abnormal physiologic states may provide a simpler understanding of some of the gastrointestinal diseases.

DR. WALTER C. JONES, Miami: I enjoyed Dr. Pate's case report and Dr. Jelks' discussion of his case. I think it is interesting to have had the opportunity of hearing the original report and to hear it again ten years later. I should like to discuss the paper from a little different viewpoint. I think Dr. Jelks' discussion was most interesting. I should like to talk a little about the difficulties we surgeons meet when we encounter a case of this type.

What is a massive resection? Dr. Pate has outlined it as accepted today, but I think it altogether possible that it depends upon whom the operation is being performed as to how massive and how dangerous it might be. It does not take many feet, if it is one of us, to make us feel that we have had a pretty massive procedure performed upon us.

The condition of the bowel when gangrene has taken place is such that it is not suitable for primary anastomosis in the majority of cases. There is great edema, which in an anastomotic procedure does not tend toward union. In the majority of our cases, therefore, in which we have had from 2 to 4½ feet to remove, we have followed the process of obstructive resection. The patients are nearly all in an extremely toxic condition, and of course that state, with loss of electrolytes, must be combated before anything is done.

At the operation the least procedure that can be carried out in some cases is life-saving. This procedure, with which you are all familiar, Dr. Lahey and Dr. Cattell described a few years ago; they simply place clamps and bring out the two ends of the bowel, making the proximal end a bit longer than the lower one and in the proximal end placing a catheter. This catheter will stay in place for a period of four to five days and as a rule will then slough out. At that time, provided the patient has lived, his condition is such that the cutting through of the spur can

be undertaken, and as a rule by the end of ten days the spur is cut through and the bowel with a firm anastomosis may be replaced in the abdominal cavity.

There has been one sad condition in handling the bowel in this manner. I can recommend this if the lesion involves the ileum. If it involves the jejunum, I do not think it is a good procedure to follow. In the last year we have had to resect about 4½ feet of bowel from a youngster. The child was in extremis. The condition was produced by intussusception of unknown cause. We could not find any reason for the intussusception in about 4½ feet of bowel which was gangrenous at the time we operated. We performed the emergency procedure, and that possibly is all this child would have stood anyhow. But the loss of electrolytes in the postoperative course and the difficulty of getting the bowel united again were such that we eventually lost the child, from malnutrition and electrolytic imbalance.

So I am convinced that this is probably a good procedure in the lower portion of the ileum. Again, it is more advantageous there because there the bacterial count is considerably higher, and with the change in the structure of the bowel it possibly tends more toward a life-saving measure in the ileum, but in the jejunum I believe that in view of the problem of controlling the electrolytic imbalance and the difficulty of getting a union in the presence of the proteolytic activity which is taking place in that part of the bowel, it is probably not the best procedure to follow. This subject leads on and on. I will not bore you further. I certainly enjoyed Dr. Pate's paper and thank him for the opportunity of discussing it.

Dr. Pate, concluding: I think the subject has been well covered by the two discussants. I wish to thank them for their time and their interest in discussing this case and also to thank the members for their kind indulgence.

Perforation of Gastric and Duodenal Ulcers: Analysis of Sixty-Three Cases at Duval Medical Center

Edward Jelks, M.D.
and
Clyde M. Collins, M.D.*
Jacksonville

This paper was undertaken for the purpose of reviewing the cases of perforation of gastric and duodenal ulcer recorded at the Duval Medical Center in Jacksonville between the years 1942 and 1950. The series consists of 63 cases, in all of which the patients were operated upon by the visiting surgical staff and senior surgical house officers during this period. The patients were typical of those frequenting a county charity hospital.

A similar paper, written by Dr. Martin Mangels[1] of Miami when he was resident at the Duval Medical Center, covers the years 1935 to 1942. The combined statistics from these two studies present a fair summary of progress in the last fifteen years. During the last eight years 190 patients have been admitted with the diagnosis of gastric or duodenal ulcer. There were 14 cases of possible gastroduodenal ulcer without roentgen confirmation and 1 case of marginal ulcer. All patients were admitted on the medical service unless the condition was complicated by perforation. On this service the usual criteria for admitting a patient with ulcer are hemorrhage, intractable pain or lack of ability to keep one's ulcer under control at home.

On the surgical service there were 62 patients admitted with perforation of ulcers proved either by surgery or autopsy and 6 additional ones in whom the ulcer was diagnosed as having perforated on clinical findings alone and who were treated with Wangensteen suction by means of a Levin tube. Only those patients with proved perforation have been included in this report. In this series 63 perforations occurred in 62 patients. One man was admitted twice, in 1942 and again in 1947, each time with an ulcer which had perforated and was subsequently closed at laparotomy. Also of interest was 1 patient who had had perforation of a peptic ulcer closed by surgery four years prior to his admission to this hospital with the same condition. Still another patient underwent surgery three times for perforation of a gastroduodenal ulcer elsewhere before coming to the Duval Medical Center for elective gastric resection.

There were 41 bleeding ulcers, 6 of which were treated by gastric resection. Five patients were admitted with symptoms of obstruction secondary to scarring at the site of an old duodenal ulcer.

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Read before the staff of the Duval Medical Center, Jacksonville, Jan. 21, 1950.

The patients admitted with perforation of a gastroduodenal ulcer from 1942 to 1950 made up 33 per cent of the entire number of patients with ulcer who were hospitalized. In the seven years from 1935 to 1942, there were 254 patients admitted with peptic ulcer, and in 62, or 24 per cent, perforation occurred. Of 444 patients with gastroduodenal ulcer admitted during the fifteen year period extending from 1935 to 1950, there were 125, or 28 per cent, in whom perforation had occurred at the time of admission or did so soon afterward.

Diagnosis

During the last eight years a correct diagnosis was made on 57 patients, with a diagnostic error of 8 per cent. In the seven years prior to that period the resident staff had also correctly diagnosed the disease in 92 per cent of the patients.

The usual diagnostic points — previous history of ulcer, exaggeration of symptoms followed by a sudden attack of sharp knifelike epigastric pain, nausea, then symptoms of shock — were noted in the majority of cases. Thirty-seven patients gave a history of symptoms of ulcer, while 26, slightly less than half, did not. An explanation for this lack of symptoms can be found in Crohn's controlled experiments[2] in which he showed that "the incidence of insensibility to pain was much higher in patients with ulcer complications than in those with uncomplicated ulcer." He further stated that "the uncomplicated ulcer patients as a class were less sensitive to pain than normal people."

The duration of symptoms exerts an influence on mortality in direct proportion to the number of hours elapsed between perforation and surgical treatment. In fact, it has often been said that the time of operation is of far greater importance than the type of operation so long as the procedure closes the perforation. In figure 1 the duration of symptoms in hours is plotted against the mortality in per cent. As the number of hours increased the mortality slowly rose. Up to seven hours there were no deaths, but at the end of fifteen hours the mortality had risen to 19 per cent. If symptoms had persisted between eighteen and twenty-four hours, the mortality rate became 50 per cent, and after twenty-four hours, the mortality increased to 83 per cent.

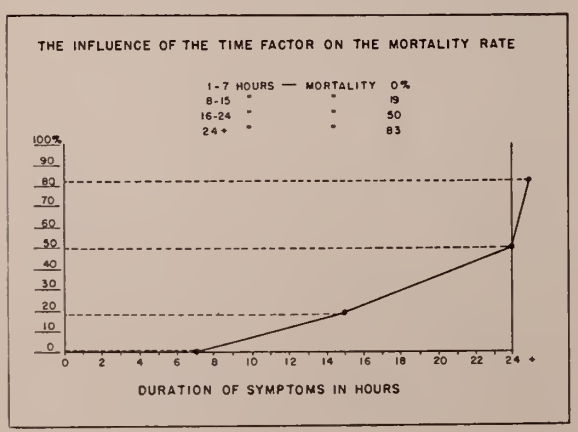


Figure 1

The group was made up of 41 white patients and 21 Negroes. Division according to sex presented 55 men and 7 women. This is a 11 per cent ratio for women which does not correspond with most authorities' reports of 2 per cent and 4 per cent. Furthermore, the women accounted for 20 per cent of the mortality.

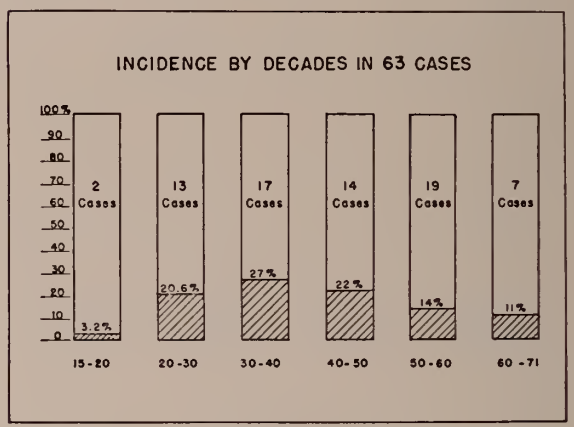


Figure 2

In figure 2 the incidence by decades is charted. The youngest patient was a 16 year old boy and the oldest a 71 year old woman. Approximately one fourth of the group was in the fourth decade, a finding which supports the statement that perforating peptic ulcer appears to be a disease affecting most often the persons in the fourth decade. The average age of the entire group was 41 years. The average age of the patients with a gastric ulcer was 48, while the age of those who had a duodenal ulcer averaged 37. Although a single case does not prove the rule, the patient who suffered from perforation of an ulcer twice in this hospital had a duodenal ulcer at his first operation when 41. Then four and one-half years later, the second surgical exploration revealed a ruptured gastric ulcer.

In contradiction to the textbook statement, vomiting was not experienced by the great majority of patients, but was reported in only 32, slightly more than half. Of the 10 patients, however, who

expired, all but 1 had vomited on admission and 2 were vomiting frequently. A history of tarry or bloody stools was elicited from only 5 patients.

Palpation usually revealed a boardlike abdomen with muscle spasm and tenderness in the upper portion. This, too, can be misleading for of those who died only 3 had a rigid abdomen and 2 were written up by the examining resident as having a "soft abdomen."

Two additional aids in diagnosis are the silent abdomen with total absence of peristalsis and a diminished area of liver dulness when the right upper quadrant is percussed.

In differential diagnosis, one must keep in mind the many disorders that simulate perforating gastroduodenal ulcer. They include: acute pancreatitis, acute fulminating appendicitis with rupture, mesenteric thrombosis, ruptured ectopic pregnancy, twisted ovarian cyst, ruptured diverticulum of the sigmoid, renal or biliary colic, a rare ulcer of Meckel's diverticulum, coronary thrombosis, arachnidism, and crises of syphilis of the central nervous system. One patient admitted with the diagnosis of perforation of an ulcer was found at autopsy to have multiple perforations of the small bowel due to many ingested fish bones. Another patient that caused some confusion was found at operation to have a perforation of a typhoid ulcer in the terminal ileum.

The average temperature on admission was 98.7 F., but this is significant only when broken down to individual cases. A patient who came in with a history of sudden severe and sharp epigastric pain less than two hours old often had a subnormal temperature while the patient who waited until eight hours after perforation before appearing at the emergency room often presented a temperature of 100 F., undoubtedly the fever of beginning peritonitis.

No single clinical feature can be relied upon for diagnosis, but roentgen evidence of pneumoperitoneum is pathognomonic of a ruptured hollow viscus. Roentgenograms with the patient in the upright position were made in 46 of the 63 cases in the series. Positive evidence of a perforated viscus was present in 83 per cent of those subjected to roentgen study. Air was seen beneath both leaves of the diaphragm in 21 patients. Twelve patients had air beneath the right leaf of the diaphragm only and 5 patients were reported merely as having "air beneath the diaphragms." In 8, the report was "no air seen;" however, in 3 the roentgenogram was not taken with the patient in the upright position. Dr. John A. Beals advised that the percentage of patients with roentgen evidence of pneumoperitoneum can be increased by taking the patient by the x-ray room just prior to surgery and getting a left lateral view of the abdomen.

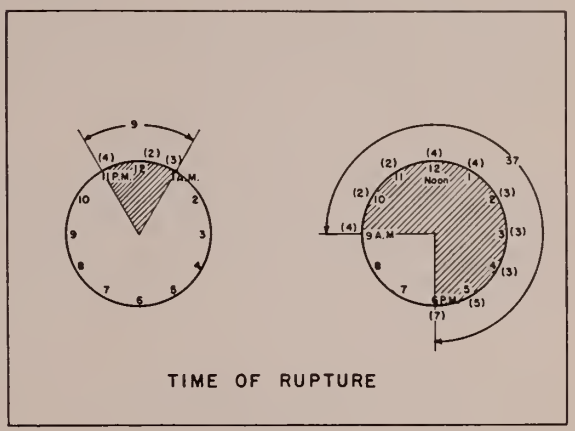


Figure 3

Time of Perforation

In figure 3 the right hand diagram represents the hours of daylight, while the left represents the hours of night. In 37, or more than half, there was history of onset of pain between the hours of 9 a.m. and 6 p.m. Only 3 reported onset of pain between 1 a.m. and 7 a.m. In 9 patients perforation occurred between the hours of 11 p.m. and 1 a.m. The mistaken consensus that most ulcers perforate at night is undoubtedly due to the fact that many patients put off coming to the hospital until four to eight hours after the onset of pain. A false lull of security is often produced by morphine given at home by the visiting doctor.

The average time elapsing between perforation and appearance at the emergency room was four hours and thirty minutes for those recovering, while for those who expired it was fifteen hours and twenty minutes. One man did not come to the emergency room until ten days after perforation. He subsequently died.

Pain

Also frequently considered pathognomonic is a history of pain in the shoulder tip. This was obtained from one fourth of the patients in this series. Unless the patient is quizzed specifically for this one symptom, he will often fail to mention it because of greater pain in the abdomen. Thir-

teen patients had tenderness in the right lower quadrant with pain and rigidity from escape of gastric content down the right colic gutter. In 3 instances in this group there was an incorrect preliminary diagnosis because onset of pain began in the right lower quadrant, and a right McBurney incision was first made.

Laboratory examination revealed an average white blood cell count of 12,750, but this was neither diagnostic nor prognostic.

Incorrect Preliminary Diagnosis

An incorrect preliminary diagnosis was made by the house and visiting staff in 10 cases. After observation for several hours, however, re-evaluation led to the correct diagnosis in 4, and the ulcer was repaired at laparotomy.

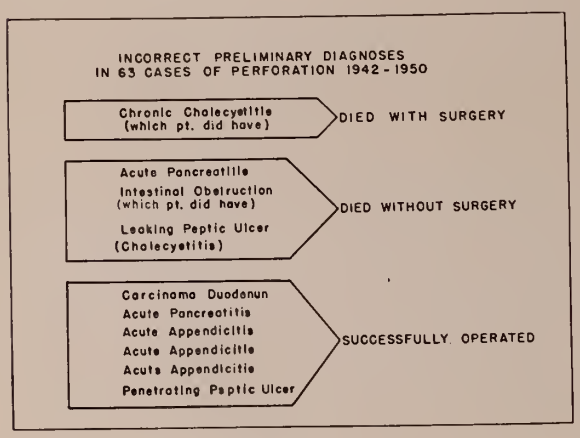


Figure 4

As shown in figure 4, in the first 5 cases, 4 of which terminated fatally, the disease was incorrectly diagnosed as chronic cholecystitis, acute pancreatitis, intestinal obstruction, leaking peptic ulcer and carcinoma of the duodenum. The faulty diagnosis directly affected the mortality rate since the delay incident to administering the therapy indicated in these conditions placed the patient in the time period with an 83 per cent mortality. The patient whose illness was diagnosed as chronic cholecystitis had a pathologic condition of the gallbladder as well as cholelithiasis. In each patient whose disease was diagnosed as acute pancreatitis, leaking peptic ulcer and carcinoma of the duodenum there developed a mass in the right upper quadrant of the abdomen, at which time the diagnosis was changed to chronic cholecystitis. The patient listed as having intestinal obstruction had an incarcerated hernia with obstruction as well as perforation of a duodenal ulcer.

The patient whose illness was diagnosed as carcinoma of the duodenum was a 51 year old divorced white man with a history of alcoholism and poor diet. He had been hospitalized four months previously with signs and symptoms of perforation of a duodenal ulcer, but after treatment with suction had been discharged improved. Approximately five weeks prior to readmission there had developed dull epigastric pain, occurring two to three hours after meals, which radiated through to the back and was unrelieved by food or milk. The abdomen was flat with tenderness of considerable degree in the epigastrium. Roentgen examination gave no help. He began to have frothy foul-smelling stools. Carcinoma of the duodenum with chronic pancreatitis was the preoperative diagnosis. At operation a posterior duodenal ulcer was found perforated and plastered to the pancreas with an abscess. A subtotal gastrectomy was performed. Three years later the patient died, and at autopsy the following were found: acute suppurative and chronic fibrosing pancreatitis, fatty metamorphosis of the liver, toxic myocarditis and gastrojejunostomy.

The next patient was a 24 year old single Negro man who had a sudden onset at 5 p.m. of severe pain in the left side of the chest which shifted to the epigastrium and then radiated to the left shoulder. There was no history of ulcer. Abdominal pain was relieved by vomiting. Pain was increased on deep breathing. The abdomen was tender and spastic, with pain of maximum tenderness in the right lower quadrant. A tentative diagnosis of acute pancreatitis was made. The patient recovered following the closure of an ulcer on the anterior surface of the duodenum.

The next 3 patients, whose illness was incorrectly diagnosed as acute appendicitis, did not affect the mortality inasmuch as the treatment for both conditions is immediate surgery. Only 1 of the 3 had a previous history of ulcer; however, each one had had sudden onset of severe abdominal pain which had localized on admission to the right lower quadrant. In each of the 3 the point of maximum tenderness was also in the right lower quadrant, and none had roentgen evidence of air beneath the diaphragm. In all, the abdomen was first explored through a lower right McBurney incision which was subsequently closed; an upper right rectus incision was then made and the perforation closed. In each of these 3 the ulcer was on the anterior surface of the first portion of the duodenum.

The last person whose diagnosis was confusing was a 32 year old white woman in prison on vagrancy charges. Eleven hours elapsed after sudden onset of pain before she was transported to the emergency room. She was admitted with a tender epigastrium and moderate rigidity. There was no air beneath the diaphragm. She had no history of ulcer. She vomited three or four times. The diagnosis was penetrating ulcer. Gastric analysis prior to surgery revealed free hydrochloric acid as 0, 3 and 5 per cent, and total hydrochloric acid as 7, 15 and 5 per cent. Pain radiated to the back, but not to either shoulder. At operation a posterior duodenal ulcer which had perforated was found. She recovered.

Surgery and Hospital Course

The average time elapsing between onset of pain or rupture and operation in the patients who recovered was six hours and forty-eight minutes. The shortest time elapsing was two hours. The average time elapsing between rupture and operation for those who expired was four days and eight hours. The average time required to get the patient from the emergency room to the operating room, for those who recovered, was two hours and eighteen minutes. The operating time varied from twenty-five minutes to one hour and fifty minutes. Sixty per cent of the patients were in the operating room less than fifty-five minutes.

The majority of the ulcers were repaired with two rows of interrupted Lembert sutures, the first being chromic catgut and the second silk. Twenty-five were repaired with one row of sutures only. Twenty-one were repaired with the Graham technic, that of tying omentum into the sutures closing the ulcer. In only 3 cases was there drainage, with no eviscerations developing.

Any surgical procedure other than simple closure is doubtfully justified. Gastroenterostomy is indicated if obstruction is present and should be preceded by gastric analysis. This obviously is a time-wasting procedure in acute perforation. The operation is for the purpose of saving a life, not electively correcting a disease that primarily should be treated by the internist. It should be the simplest repair known to the surgeon.

The size of the perforations ranged from 2 mm. to 1.5 cm. The average size was 0.5 cm. The size was mentioned in only 36 operative reports. Seventy-nine per cent were reported as anterior and 6 per cent as posterior. In the remainder the position was not mentioned. In 5 of the 10 cases terminating fatally, the ulcer was reported as anterior, in 3 merely as "lesser curvature" and two "posterior." Fifty-eight per cent of the lesions were reported as duodenal and 42 per cent as gastric. These figures are not in accord with the ratio of 4 duodenal to 1 gastric ulcer, as given by many observers. This difference is due in part to the human error which cannot be entirely eliminated among the various surgeons operating as well as to the difficulty in establishing the exact site of the pylorus.

Anesthesia

In those who recovered, more than half were operated upon under cyclopropane; ether was the agent in 15 per cent, spinal anesthesia was used in 17 per cent, and general and spinal anesthesia combined was used in 10 per cent.

Postoperative Treatment

Thirty-one patients were treated with penicillin; 4, or 13 per cent, of these died. Penicillin was first used on patients in critical condition in 1945 when the supply was available, then begun almost routinely in 1946 with no deaths that year. Streptomycin was first used in cases of perforating peptic ulcer in 1948 and is now used rather routinely. In 6 out of 8 cases last year streptomycin was given. Sulfanilamide powder was sprinkled into the peritoneal cavity routinely until 1944, at which time it was only used occasionally. In 1945 the staff reached the conclusion that it was of no help and discontinued putting it into the abdomen. Routinely a Levin tube with constant Wangensteen suction was employed postoperatively. It was left in place until peristalsis became normal. Prior to discharge from the hospital each patient should have a gastric analysis and roentgen examination of the gastrointestinal tract. These will serve as a base line for comparison with future studies, should the patient fall into the large group whose ulcer is not obliterated by simple closure.

Mortality

The mortality rate is affected by many factors: time elapsing between rupture and surgery, age, general condition, correct diagnosis, anesthesia, surgical procedure, coexisting disease, complications and use or nonuse of chemotherapy and antibiotics. The over-all mortality with 10 deaths was 16 per cent. Excluding the 4 patients not operated on would give an operative mortality of 9.5 per cent. In the last four years there have been 37 cases of ruptured ulcer with 3 deaths, giving a mortality of 8 per cent, but the 3 patients

ANALYSES OF 63 CASES OF PERFORATION WITH GROSS MORTALITY OF 16%

DURATION OF SYMPTOMS	RECOVERED		DIED		TOTALS
	CASES	%	CASES	%	
1 - 7 Hours	37	100	0	0	37
8 -15 Hours	13	81	3	19	16
16 -24 Hours	2	50	2	50	4
24 + Hours	1	17	5	83	6

Figure 5

who died were not operated upon, which equals an operative mortality of 0 per cent.

Bockus[2] stated that by far the most important factor in determining the mortality following free perforation is the time elapsing between the occurrence of catastrophe and operation. If a patient came to the Duval Medical Center after the ulcer had perforated and had reparative surgery within seven hours, his chances of getting well were perfect (fig. 5). After eight hours, however, the odds were reduced, and at fifteen hours the mortality rate was 19 per cent. When twenty-four hours had elapsed his chances of getting well were only two out of four, and after twenty-four hours he only had one out of six possibilities of recovering. This series further proves the oft stated fact that the mortality rate rises steadily with the older groups of patients. This rise may be explained in part by the greater number of concurrent and complicating illnesses they suffer, such as cardiac and renal disease, diabetes and malnutrition. As shown in figure 6, no deaths occurred until the fourth decade, but then the mortality, after staying on approximately the same level, jumped suddenly in the seventh decade to 71 per cent. In 3 of the 5 in the last group who expired the disease was incorrectly diagnosed, and only 1 of these was operated upon. In 1 case of the series the age was not recorded.

A few of the variables on the 10 patients who died are as follows: They ranged in age from 36 to 71; the average was 54. The age of those whose disease was incorrectly diagnosed averaged 67.5 years. Those in whom the condition was incorrectly diagnosed on admission did not come to the emergency room until approximately fifteen hours after perforation had occurred.

Eight of the 10 said they had experienced sudden onset of pain or that they had been aroused from sleep by the pain. Symptoms of perforation had been present anywhere from eight and one-half hours to ten days. In the 2 patients under 40 years of age perforation had occurred over twenty hours before they were operated upon. One patient, 40 years old, expired four and one-half months postoperatively of an abscess of the liver prior to the days of antibiotic therapy. The disease in 4 patients was incorrectly diagnosed. Three of these were not operated upon. In 4 of those who died there was roentgenographic evidence of pneumoperitoneum. Peritonitis was the cause of death in all 10, abetted by other pathologic conditions including cirrhosis and abscess of the liver, malnutrition, syphilis and chronic cholecystitis.

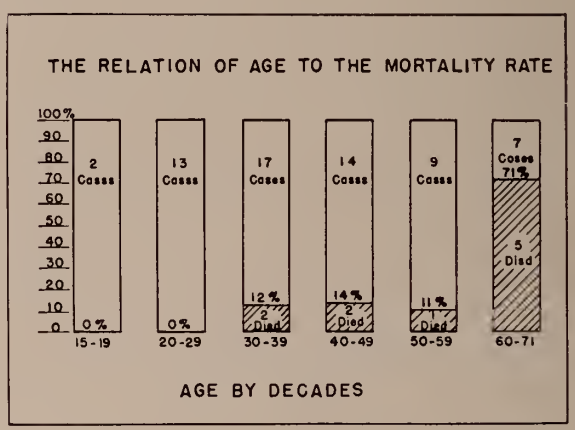


Figure 6

Summary

In the last eight years there have been admitted to the Duval Medical Center 62 patients with 63 perforations of gastroduodenal ulcers. One patient was admitted for two separate perforations. In the seven years prior to this period 62 patients with the same condition were admitted, making a total of 125 perforations of peptic ulcers diagnosed and confirmed in the last fifteen years, from 1935 to 1950.

In 10 cases of this series covering the last eight years there was an incorrect preliminary diagnosis. On postmortem examination, in 2 of these patients the pathologic condition predicted was present as well as perforation of an ulcer. In 4 cases, after several hours' observation, the disease was correctly diagnosed, and the patient was operated upon and recovered. Diagnosis was 92 per cent accurate, while in the earlier period it was also correct in 92 per cent of the cases. Thus, the

fifteen year over-all diagnostic error was 8 per cent.

The average time elapsing between perforation and arrival at the emergency room was four hours and thirty minutes for those who survived. The average time between perforation and operation for those who recovered was six hours and forty-eight minutes. Thus it required an average time of two hours and eighteen minutes to get the disease diagnosed and the patient ready for surgery. This is an improvement over the time of three hours and fifteen minutes required for the same procedure from 1935 to 1939.

In the earlier seven years, drainage was employed in 9 cases; in 6 there were eviscerations, and in 3 the patient died. In this series there was drainage in only 3 cases over a period of eight years, with no eviscerations. Roentgen examination of 46 patients revealed pneumoperitoneum in 38, or 83 per cent. In the period from 1935 to 1942 only 31 patients were subjected to roentgen studies, with 64 per cent of them showing air beneath the diaphragm.

The postoperative period of hospitalization was decreased from twenty-eight days during the 1935 to 1939 period to eighteen in the 1939 to 1942 period, and between 1942 and 1950, it was reduced to sixteen days.

The mortality rate progressively decreased from 42 per cent in the period from January 1935 to July 1938 to 31 per cent in the period from July 1938 to January 1942 (fig. 7). This change was thought to be due to inauguration in July

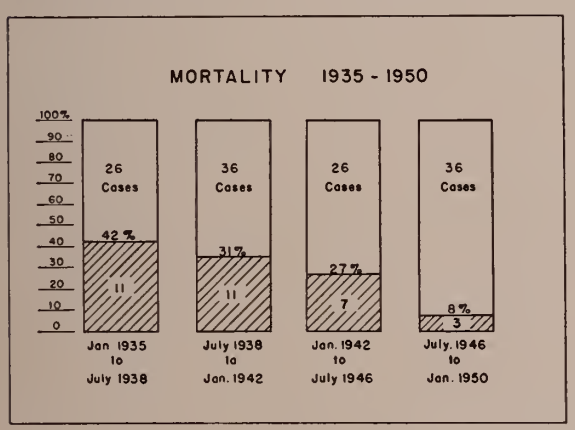


Figure 7

1938 of a residency system with surgery available immediately when necessary. It was further lowered to 27 per cent in the four years from 1942 to 1946. This additional reduction can be credited in part to the use of chemotherapy, locally and parenterally, with a decrease in pulmonary complications, infection of wounds and peritonitis. During the last four years, 1946 to 1950, the mortality has been lowered to 8 per cent, an improvement which can be attributed to the routine use of the antiobiotics (penicillin and streptomycin), and omission of intraperitoneal drains, which has practically eliminated such complications as eviscerations, empyema, and subhepatic and subdiaphragmatic abscesses.

Conclusions

Analysis of treatment of 125 cases of perforation of gastroduodenal ulcers, reported on the surgical service of this hospital covering a fifteen year period from 1935 to 1950, leads to the following conclusions:

Perforating ulcers may occur at almost any age. The youngest patient was 16 and the oldest 71 in the present series covering the last eight years. Approximately one fourth of the patients were in the fourth decade.

The age of the patient is important to prognosis, as mortality progressively rises with age. The earlier a diagnosis is made and surgery performed the better the prognosis.

Signs and symptoms vary. Approximately half of the patients in this series had typical signs and symptoms of perforation of an ulcer. The other 50 per cent had a variety of symptoms; 42 per cent gave no previous history of ulcer, and only 25 per cent mentioned pain in the shoulder tip. In more than half of the cases perforation occurred between 9 a.m. and 6 p.m. In 8 per cent there were tarry stools. In some, the abdomen was soft. In some, tenderness was present in the right lower quadrant, in others, the right upper quadrant. Pneumoperitoneum served as an aid in making the diagnosis in more than two thirds of the cases.

One perforation does not safeguard a patient from a second or even a third perforation.

Postoperatively, chemotherapy, antibiotic drugs and gastric suction should be used routinely.

Finally, repeated examinations at regular intervals should be made, exhausting all diagnostic aids in an attempt to determine which disease the patient may have, especially in cases of undiagnosed conditions occurring in aged persons suffering from nausea, vomiting and abdominal pain.

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Duval Medical Center.

The Insulins and Their Uses

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Insulin is that hormone secreted by the pancreas which enables the animal organism to utilize carbohydrate satisfactorily as a source of energy. It was first isolated and prepared by Banting and Best in 1922. The insulin isolated by them, and now called regular or unmodified insulin, is probably the true hormone as it exists in the organism.[1a]

No sooner had the hormone been isolated and its potentialities and limitations realized than efforts were made to modify the original insulin to enhance the ease and effectiveness of its utilization. These efforts have resulted in the appearance of four types of insulin available for the treatment of diabetes mellitus. Each of these types has its own rate and duration of action and has its place in the therapy of the diabetic patient. These types are: regular or unmodified insulin; protamine zinc insulin; globin insulin with zinc; and mixtures or modifications of protamine zinc insulin.

Regular (Unmodified) Insulin

Regular (unmodified) insulin is a simple solution of the true hormone and is usually given subcutaneously. Its rate of action is the most rapid, the most intense, and the least prolonged of all the insulins. On the average in the diabetic patient, the response to a single dose of regular insulin is demonstrable within an hour, reaches its intense peak in from three to six hours, and is exhausted in from eight to twelve hours after injection (table 1).

This was the first and the only insulin available from 1922 until 1935. The intensity and shortness of duration of its action made it a somewhat unwieldy, although effective, weapon in the routine treatment of diabetes. Multiple injections were usually necessary, so that some diabetic patients had to take as many as three doses a day, and a few had to take four each day. In 1935, however, the appearance of protamine insulin changed this state of affairs considerably, so that at the present time regular insulin alone is rarely used in the routine treatment of persons with diabetes. Nevertheless, it has many uses. Its prompt and intense action makes it the insulin of choice in circumstances in which quick insulin action is essential, such as in ketosis, intercurrent illness, surgery, or any other acute complication.

Regular insulin under such circumstances should be used with due consideration for its time-action characteristics. Multiple doses must usually be given, and there should be some overlapping of effect; therefore, the doses should never be more than six hours apart. On the other hand, the doses should never be less than three to four hours apart, in order that there may be no cumulative effect. The practice of giving regular insulin every half hour or every hour in diabetic ketosis may lead to cumulative effects which might be confusing.

A typical example of the use of regular insulin is in diabetic ketosis. The routine discussed is a modification of the one suggested by Joslin and his associates.[2] Only the insulin dosage schedule is presented (table 2). It will be noticed that, even while the ketosis is at its worst, the insulin is given no more frequently than every three hours. This schedule allows the laboratory determinations, namely, the blood sugar, the CO_2 combining power and the urine sugar, to give a fairly good index of the effectiveness of the previous dose of insulin. From the second to the sixth hour, the insulin is given every four hours, and the amount of insulin given is governed by the amount of sugar in the urine; that is, the amount given in 5 units for each plus grading of sugar in the urine (according to the Clinitest or Benedict's method).

The method of ordering insulin every four to six hours as so many units per plus urine sugar according to the Clinitest or the Benedict's test may be used in other emergencies besides that of ketosis. It can be helpful in the treatment of the diabetic patient during acute febrile episodes and during surgical emergencies. Under these circumstances, 3 or 4 units per plus urine sugar may be used, depending on the severity of the illness.

Read at the Northeast Medical District Meeting, Ocala, Nov. 1, 1950.

Regular insulin is also used in supplementing the long-acting insulins. These latter have definite limitations in the therapy of the moderately severe and severe types of diabetes, and in most cases must be supplemented by regular insulin given either separately or in combination with the depot insulin.

Protamine Zinc Insulin

Protamine zinc insulin is the most popular of the long-acting insulins, and was first introduced by Hagedorn in 1936.[3] It is produced by combining the acid insulin compound with a basic monoprotamine. This early protamine insulin complex, when first used, was shown to have a much more prolonged action than regular insulin, having a demonstrable effect more than twelve hours after injection. Soon afterward, zinc was added to the complex,[4] and the result was the protamine zinc insulin used today.

The time-action characteristics of protamine zinc insulin are as follows: Four hours after administration of the insulin, the effect is demonstrable. It reaches a prolonged peak of from sixteen to twenty-four hours. This peak is considerably less than that of unmodified insulin, being only about 20 per cent of the latter, unit for unit. Since the effect of each dose of protamine zinc insulin lasts for three days, the daily administration allows for an overlapping of effect and an increase in intensity of the insulin effect. This results in a tendency to hypoglycemia in the fasting period.

Promatine zinc insulin is used to provide a sustained insulin effect with a single daily dose of insulin. It is especially effective in mild diabetes, in which only small doses are required. When larger doses of insulin are needed, however, it is not satisfactory when used alone. The constant steady sustained insulin effect cannot be modified

Table 1. — Time-Activity of Single Large Doses of Various Types of Insulin in Diabetes Mellitus of Moderate Severity (Approximate)

Type of Insulin	Action Demonstrable	Peak Action	Intensity at Peak	Duration of Effect
Regular or crystalline	1 hour	3-6 hours	Strong	8-12 hours
Globin with zinc	2 hours	8-12 hours	Fairly strong	24 hours at most
2:1 mixture	4 hours	12-16 hours	Moderate	1½ to 2 days
Protamine zinc	4-8 hours	24-32 hours	Weak	3 days or more

Table 2. — Insulin Dosage Schedule in Diabetic Ketosis

First hour after admission	Insulin: 100 units regular immediately for adults if blood sugar exceeds 300 mg. per hundred cubic centimeters and if the blood CO_2 content is 9 millimols or less (20 volumes per cent). The dose would be less in cases of recent onset of diabetes or in young children. For blood sugars between 600 and 1,000 mg. per hundred cubic centimeters, give 200 units additional, and for blood sugars over 1,000 mg., give 300 units additional.
Second to sixth hour after admission	Repeat blood sugar and CO_2 determinations after three hours. For rising blood sugar, give 50 to 200 units of insulin, depending on the physician's judgment.
Sixth to twenty-fourth after admission	Repeat blood sugar and CO_2 determinations, and give 50 to 200 units of insulin if blood sugar and CO_2 levels have not improved. If the fall in blood sugar has been satisfactory, regular insulin may be given every four hours according to the urine test:
	Red (4+) 20 units; Orange (3+) 15 units; Yellow (2+) 10 units; Green (1+) 5 units; Blue (neg.) 0 units

to handle the hyperglycemia resulting from food. If amounts of protamine zinc insulin large enough to prevent hyperglycemia after meals are given, the hypoglycemic effect during the night may be great enough to result in insulin shock. This usually occurs from about 4 a.m. to 6 a.m.

It can be readily understood that this characteristic is extremely undesirable. The early morning is a bad time for an insulin reaction because the patient is asleep. Furthermore, the hypoglycemia which results from protamine zinc insulin is gradual and slow, and may go unrecognized for years.[5] This may be complicated by the paradoxic glycosuria of Bowcock.[6] In these instances, the hypoglycemia resulting from protamine zinc insulin may be slow and asymptomatic. The lowered blood sugar causes the release of sugar from the liver, usually in amounts which cannot be readily utilized. Glycosuria then occurs, and the patient is led to increase his insulin dosage.

In the use of protamine zinc insulin alone, if more than 20 units is given and there is no glycosuria throughout the day, there is probably overdosage and possible early morning hypoglycemia. Such prolonged unrecognized hypoglycemia has been held by Mosenthal and others to be the cause of some of the degenerative lesions commonly ascribed to the diabetes itself. Hypoglycemia of this type is especially dangerous in the presence of disease of the coronary arteries, when such hypoglycemia may precipate coronary insufficiency or myocardial infarction. For this reason, if more than 20 units is needed, the protamine zinc insulin should be complemented with regular insulin, either in combination or by separate injection.

Globin Insulin with Zinc

Globin insulin with zinc was first introduced by Reiner, Searle and Lang.[7] It was prepared in an effort to improve on protamine zinc insulin without sacrificing the advantages of its prolonged effect. It is prepared by the addition to insulin of zinc and of globin prepared from beef hemoglobin. As it is now prepared, it is a clear solution which has a type of action intermediate between that of protamine zinc insulin and of regular insulin.

Although on the surface it would seem that its time activity, intermediate between protamine zinc insulin and regular insulin, would make it ideal for routine use, this has not proved to be true. The reason is that its action is not sustained enough to allow for the overlap so necessary in severe diabetes. The effect of a single dose of globin insulin begins in two hours and has an intense peak effect in eight to twelve hours, after which significant waning occurs. Although the effect lasts for twenty-four hours, the intensity of action at the end of that time is insignificant.

Globin insulin can be used to control mild diabetes without any difficulty. When the diabetes is more severe, however, its deficiencies are apparent. In a single large dose, the intensity of action after six to eight hours causes afternoon insulin shock. Its lack of effect in twenty-four hours fails to permit the overlapping effect so necessary for adequate control, so that high blood sugars and glycosuria before breakfast are the rule. Therefore, while globin insulin is widely used in mild diabetes, it is not suitable when the disease is severe, since it does not have the adequate overlap characteristics of the ideal preparation. The ideal preparation must act long enough to provide some overlapping from day to day, or it will not provide enough insulin activity to metabolize a normal-sized breakfast, nor will it prevent nocturnal hyperglycemia. This overlap is what Joslin has termed "insulin insurance from one day to the next."

In the continuing efforts to find an insulin which would produce good control with a single daily injection in severe diabetes, various mixtures of protamine zinc insulin and regular insulin have been studied since 1942. Studies made then[1b] demonstrated that when regular insulin is added to protamine zinc insulin, an excess of the former is required to modify the time-effect characteristics of protamine. Further studies showed that such a mixture of the two insulins results in new protamine zinc entities with accelerated activity.[1c] These studies revealed that, of all mixtures, a preparation containing twice as much unmodified insulin as protamine zinc insulin (2 to 1 mixture) possesses the most desirable characteristics for a single dose injection each morning in severe diabetes. Such a preparation does not contain either insulin as such. When the two insulins are mixed,[1a] a suspension of a new variety of protamine zinc insulin is formed. This compound contains one third as much protamine as the standard protamine zinc insulin and represents an insulin-saturated protamine zinc complex which, on injection, releases its insulin more rapidly during the first twelve hours than during the second. Its effect, therefore, is stronger during the first twelve hours than that of protamine zinc insulin and weaker during the second. For this reason, it is more

capable of controlling the postprandial glycosuria than protamine, and less likely to cause insulin shock. There is still, however, sufficient protamine effect to control the fasting level and to allow for adequate overlap.

There have been many studies of the use of mixtures of different strength. Although the 2 to 1 mixture is suitable in most cases, a 3 to 1 or even 4 to 1 mixture is suitable in an occasional case. Of those patients who need more than 40 units daily for adequate control, more than 60 per cent will need mixtures especially prepared for the individual patient.

At this point, it may be of interest to outline a regimen by which the diabetic patient is brought under control and to show how the final mixture is obtained. I shall begin with a patient who has just been brought out of ketosis and is well enough to be placed on a diabetic diet, or a patient who is uncontrolled but has not been in ketosis. In both cases, the routine will be the same.

The patient is placed on a diabetic diet adequate in carbohydrate and calories. He is given ten units of protamine zinc insulin the first morning before breakfast. Specimens of urine are checked for sugar before each meal and at bedtime. Supplementary doses of regular insulin are given after each of these tests, the test being a guide to the amount to be given, with the formula of 4 units of insulin per each 1 plus urine sugar. The protamine dose is increased by 5 units daily until the fasting urine is almost sugar free. At this time, the amount of insulin required daily is computed, and the multiple injections are replaced by a single dose of the 2 to 1 mixture. This mixture is then varied in the following manner:[5]

Examination of two specimens of urine a day is now necessary, one before the morning meal and the other before the evening meal. Sugar in the urine before the morning meal calls for more protamine zinc insulin (more late action); whereas sugar in the urine before the evening meal demands more soluble insulin. When the test of the morning urine has been 3 or 4 plus (Clinitest or Benedict's method) for three or four mornings in succession, the protamine zinc insulin is increased by 2 or 4 units. Likewise, when examination of the morning urine has given negative results for three or four days (usually not more than three), the protamine zinc element is reduced by 2 or 4 units. The presence of mere traces of sugar in the urine in the morning does not require any change in the amount of protamine and provides an assurance that the dose of protamine is not excessive.

When the result of the urine test before the evening meal has been 3 or 4 plus for three or four days, the regular insulin component of the mixture is increased from 2 to 4 units. The change is made on the following morning. Likewise, when the urine test gives negative results before the evening meal, the regular insulin component is reduced by 4 units.

When reasonable control has been achieved, it is not advisable to make frequent changes. Transient glycosurias resulting from emotional disturbances or variation in food intake should not lead to changes in the doses of the two insulins. The occurrence of an insulin reaction, however, should call for a lowering of the next day's insulin. When the reaction has developed between breakfast and supper, the regular insulin component should be decreased. If it has developed in the night, the protamine content should be lowered. The magnitude of the changes made in the insulin dosage depends on the size of the total daily unitage of insulin. When it is more than 40 units, changes are desirable in steps of 4 units; when it is less, changes of only 2 unit variations are desirable.

In regulating a fairly severe diabetic patient, the situation sometimes arises in which the fasting specimens of urine and those before the evening meal and at bedtime give a negative reaction, but there is considerable sugar in the urine just before the midday meal. At times, this may even occur when there is also a slight insulin reaction in the early afternoon. It is usually due to a fairly high fasting blood sugar without glycosuria, combined with a breakfast containing too much carbohydrate. Although this glycosuria occurs during the day, when one would expect the control to be effected by the regular insulin component, it is best handled by increasing the protamine zinc insulin component and decreasing the carbohydrate in the morning meal.

Prepared Mixtures

Despite the effectiveness of insulin mixtures and their flexibility, they have many disadvantages. The procedure of mixing is difficult to teach to some patients. It is unsuitable for the ignorant or for those who are handicapped by poor vision. For these reasons, at least twenty modifications of protamine zinc insulin have been advocated and tried since 1944. In the past, none of them has proved quite successful, owing either to instability

of the mixture or to undesirable, unpredictable hypoglycemic effects. In at least one case, a mixture was prepared which was satisfactory clinically but which could not be produced satisfactorily as a commercial product. Since 1945, however, a modification has been used fairly successfully by many investigators and is now being produced satisfactorily as a commercial product. This is the preparation known as NPH 50. The N stands for neutral, the pH of this insulin being 7.2 in contrast to regular insulin, which is acid with a pH of about 3.0. The P is for protamine; the H is for Hagedorn, who developed the method of preparing the crystals of this protamine zinc insulin as used in NPH 50. The 50 refers to the approximate quantity (.50 mg.) of protamine contained in 100 units of this insulin. This protamine zinc insulin, as used, is a suspension of stable tetrahedral crystals.[8]

Regular insulin can be added to this insulin without loss of its characteristic quick action. On the other hand, protamine zinc insulin has 1.2 mg. of protamine in 100 units of insulin, is a suspension of an amorphous precipitate, and causes a loss of the characteristic quick action of the regular insulin added to it. The excess of protamine in the original protamine zinc insulin is necessary for the stabilization of the compound, and it is this excess which modifies the regular insulin added to it so that regular insulin must be added in amounts greater than the protamine if any of the quick action is to be retained. For example, when 20 units of regular insulin is added to 10 units of protamine, the resulting time action is much as though the patient had 20 units of protamine and 10 units of regular insulin injected separately.

The time-action characteristics of NPH 50 are similar to those of the 2 to 1 mixture, but with slight differences. These differences are that the intensity of the peak in NPH 50 is somewhat less than in the 2 to 1 mixture, but is more sustained[8] and the overlap effect is much greater.

NPH 50 has been extensively studied and has been found to be of some help in the problem of the severe diabetic patient, but it is definitely not the final answer, since it gives good control in approximately only 40 per cent of severe diabetic patients. By severe diabetic patients is meant those needing over 40 units of insulin.[9] The other 60 per cent in that category can only be controlled by the use of especially prepared mixtures for the individual patient, or by giving separate injections of a depot insulin and quick-acting regular insulin.

General Therapy

It would be worth while at this time to add a few words about the therapy of diabetes in general. A goodly percentage of diabetic patients, estimated at between 40 and 50 per cent (depending on the observer), can be satisfactorily controlled with diet alone. Of the remainder, the vast majority can be easily controlled with diet and less than 20 units of insulin a day. These patients can use either protamine zinc insulin or globin and maintain satisfactory control. Then, there is the group whose diabetes is fairly stable and who need between 20 and 40 units a day. They can usually be controlled with diet and either a 2 to 1 mixture or NPH 50. Some of these patients do fairly well with globin. Occasionally, in this group of those who need under 40 units, one finds a "brittle diabetic," but this type is usually in the group who need more than 40 units.

In the group who need more than 40 units, approximately 40 per cent can be controlled with one injection a day of either 2 to 1 mixture or NPH 50. The other 60 per cent require in each case either an especially prepared mixture of protamine zinc insulin or NPH 50, and regular insulin in one daily injection or separate injections of a depot insulin and regular insulin.

Summary

The various types of insulin, their time-action characteristics, and their uses are discussed. The requirements of the diabetic patient, classified roughly as to severity of the disease, have been set forth, and methods of meeting these requirements with the available forms of insulin have been brought out.

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The Cervical Stump—Necessary Evil?

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The management of the retained cervical stump, a relatively common gynecologic problem, has been brought about by the frequency of hysterectomy for uterine disease. Not infrequently, pelvic organs are removed for the relief of pelvic pain and the cervix left behind when the cervix is primarily responsible for the symptoms. Suffice it to say that many of the patients in such cases obtain little or no relief. On the other hand, the patient may have been relieved by extirpation of pelvic organs producing pain only to have a pathologic process develop in the cervical stump, producing many uncomfortable symptoms. While the literature abounds with articles dealing with carcinoma of the cervical stump, little has been written concerning benign lesions of the retained cervix.

An analysis of 16 cases of diseased cervical stump from my private practice in the past three years, all of which were sufficiently symptomatic and diseased to warrant treatment, form the basis of this communication.

Symptomatology

Multiplicity of symptoms was the general rule, and the nature of these symptoms is found in table 1. In this series the average age was 40.8 years, the average number of pregnancies was 4, and there were 4 cases in which the patient had never conceived. In practically all cases the patient had had previous surgery for fibroids, with or without bleeding, and in a few for chronic pelvic inflammatory disease. Many of the patients had pelvic complaints that were unrelieved by the initial surgery, and not a few had experienced multiple surgical procedures. The commonest complaints were pelvic pain, leukorrheal and/or bloody discharge and dyspareunia.

Pelvic pain was described usually as a chronic, dull ache occurring in one or both iliac fossae, which was often aggravated by intercourse or lifting heavy objects. Gynecologic texts do not stress the importance of pelvic pain brought about by a diseased cervix. Collins and his associates[1a] stressed the importance of evaluating pelvic complaints by motion of the cervix. The important factor is the reproduction of pain and not the production of pain. When fixed pelvic masses are present, pressure on them will generally reproduce some of the complaints if these masses are responsible. In the absence of such pathologic conditions the following clinical test described by Collins is of great value. The examining finger should be gently inserted into one lateral fornix and the cervix pushed to the opposite side of the pelvis. The resulting tension on the contralateral cardinal ligament often reproduces the patient's complaint of pelvic pain. It is highly important to inquire if the pain is actually reproduced and not merely "does it hurt?" A patient with the complaint of low backache will often volunteer that the backache is readily simulated by pushing the cervix forward and putting the tender uterosacral ligaments on the stretch. Frequent dysuria is often the end result of lymphatic extension of infection from the cervix to the bladder via the lymphatics in the pubocervical fascia. Many of these very patients are classed as therapeutic failures by the urologist. Dyspareunia is an especially common complaint, and unfortunately far too many physicians completely overlook inquiring into the patient's sex life. The pain is most often deep-seated and may be described as if "something sore is being struck." I have repeatedly elicited this story from many patients, and not infrequently because all is not well at home is the main reason for the visit. This type of pain can be readily reproduced

Table 1

Symptoms	Number of Cases
Leukorrhea	8
Bloody discharge	7
Pelvic pain	11
Dyspareunia	10
Backache	6
Dysuria	5
Bearing down pain	3

Read at the Northeast Medical District Meeting, Ocala, Nov. 1, 1950.

by gently pushing against the cervix. The feeling of a bearing down sensation is most often due to poor support of the cervical stump and vaginal vault. One may place a tenaculum on the retained cervix, and slight traction will elicit this uncomfortable symptom. Needless to say, no examination of the cervix, whether the corpus is present or not, is complete without sounding the canal. This, of course, is not done when there is a possibility of intrauterine pregnancy.

Pathology

The various pathologic findings in this small series are noted in table 2. One should not infer

Table 2

Pathologic Findings	Number of Cases
Chronic and chronic cystic cervicitis	16
Polyps	1
Stenosis	2
Epidermoid carcinoma (carcinoma in situ)	1
Large Mucocele	1
Cervicovaginal fistula	1
Atropic vulvovaginocervicitis	3

that every cervical stump examined in the office is diseased, for this finding does not hold true. It is, however, significant that in 11 of the 16 cases reported the stump was sufficiently diseased to warrant its extirpation. It is obvious from the histories in these cases that the majority of the patients had diseased cervices at the time the subtotal hysterectomy was performed. It is believed that in the 1 patient who on office biopsy had a carcinoma in situ, this pathologic condition was present when the initial hysterectomy was performed. It is important to point out that 7 patients or almost 50 per cent of the series had a bloody discharge. Davis and Cheek[2] strongly recommended that any patient who has vaginal bleeding following supravaginal hysterectomy should have the cervical canal curetted and multiple biopsies taken. There were 2 cases of stricture of the cervical canal from previous multiple cauterizations, and in 1 of these the stricture was associated with a large mucocele. In 1 case there was present a large granulating cervicovaginal fistula which was located high in the posterior fornix. Many of the retained cervical stumps presented, in addition to chronic cystic cervicitis, old lacerations and erosions.

Treatment

If routine examination reveals a healthy asymptomatic cervical stump, it is only necessary that the patient be told of its existence and advised to have periodic examinations. A first or second degree prolapse of a healthy cervical stump requires only observation. If a third degree prolapse is present, regardless of the absence of a pathologic condition, the stump should be excised and the vaginal vault resupported. While sulfonamide drugs and the antibiotics are exceedingly useful in the management of acute cervicitis, their value in a chronically diseased cervix is doubtful. As in the case of any diseased cervix, the choice of treatment depends upon the type and degree of pathologic change present in the retained stump (table 3).

Table 3

Method of Treatment	Number of Cases
Vaginal removal of cervical stump	6
Vaginal removal of cervical stump combined with vaginal plastic procedures	3
Vaginal removal of cervical stump with postoperative high voltage roentgen therapy	1
Abdominal removal of cervical stump with bilateral salpingo-oophorectomy and drainage of large benign retroperitoneal cyst	1
Office cauterization and local therapy	5

Simple erosion and superficial infection may be handled by actual cautery in the office. It is important, however, that the patient return for soundings lest cervical stricture occur. When there is considerable chronic infection with parametritis, cystic degeneration, severe lacerations and erosions or when the cervix reveals hypertrophy sufficient to produce symptoms, the only certain method of cure is extirpation of the stump. It is believed that repeated cauterizations or conizations in such cases are obsolete. It has already been noted that any patient who presents herself with a bloody discharge should have multiple biopsies of the stump prior to surgery.

There are those who hold that the removal of a cervical stump is a formidable undertaking. Such is not the case. Te Linde[3] believed that it is safer to remove a cervical stump from above, fearing danger of damage to the bladder by vaginal removal. It is my practice to remove the retained stump vaginally according to the technic described by Tyrone and Weed.[4] An elliptic incision is made around the cervix, and the vaginal mucous membrane is then dissected from the cardinal ligaments laterally and the uterosacral ligaments posteriorly. The bladder is carefully dissected upward, and the entire cervical stump is readily removed by dividing the cardinal and uterosacral ligaments. One need not enter the peritoneal

cavity, and the vaginal vault is readily supported by approximation of the uterosacral and cardinal ligaments. The vault is closed by deep interrupted sutures. If there is a symptomatic cystocele and/or rectocele present (as is the case in many patients), an anterior and posterior repair can be readily made at the same time. Morbidity is rare, and the patients are up early and usually home in a week. In the cases in which atrophic changes manifest themselves, it is important to use local estrogens from time to time postoperatively.

Results

There were no deaths nor complications in this series (table 4). It is believed that the vaginal approach entails no danger to either the bladder or the ureters. Ten patients had complete relief from their initial complaints. Partial relief was experienced by 2 patients; one still had pain in the right lower quadrant of the abdomen and the other had a bilateral pudendal nerve neuralgia which was finally relieved by several pudendal nerve blocks. The 1 patient who had no relief refused extirpation of the diseased cervical stump, and local treatment was of no value. Three cases are too recent to evaluate the result. Included here is the 1 case of carcinoma in situ.

Discussion

The only hysterectomy that should be performed in our day, except under extenuating circumstances, is a total abdominal or total vaginal hysterectomy. Most large clinics have inclined toward complete hysterectomy but many general surgeons, the occasional surgeon and even many gynecologists still adhere to the principle of subtotal hysterectomy. In properly trained hands there should be no appreciable difference in operative mortality or morbidity. Such procedures as subtotal hysterectomy combined with deep cauterization of the cervix, "coning out" of the cervix and amputation of the cervix should belong to the past. The same lesions that are found in an intact uterus similarly affect the cervical stump. There may develop erosions, cervicitis, hypertrophy, cysts, cancer, strictures and fibroids, which reproduce pelvic pain, leukorrhea, dyspareunia, backache, urinary discomfort and bearing down pains. Far too often the surgeon does not take the trouble adequately to examine the cervix or evaluate the complaints by clinical tests prior to surgery. The literature is replete with large series of cases of carcinoma of the stump in which some degree of malignancy was undoubtedly present when the subtotal hysterectomy was performed. This oversight is inexcusable. Adherents to subtotal hysterectomy hold that the cervix is necessary to a happy sexual congress. Nothing could be more fallacious. The cervix is not necessary for proper support of the vaginal vault. If careful approximation of the supporting structures of the uterus (cardinal and uterosacral ligaments) is skillfully carried out, there will be no prolapse of the vault. Some maintain that total hysterectomy shortens the vaginal vault. If the proper technic is carried out, there will be no such shortening. Collins[1b] stated that members of the Section on Gynecology and Obstetrics at the Ochsner Clinic have performed 2,000 hysterectomies from the time of its establishment in January 1946 to January 1950 with 2 deaths, a mortality of 0.1 per cent. These figures included 21 cases of the radical Wertheim operation for cervical cancer. Of this large series of hysterectomies, 98.6 per cent were total in type.

Table 4

Results	Number of Cases
Mortality	0
Complications	0
Complete relief	10
Partial relief	2
No relief	1
Incomplete follow-up	3

Summary

Not infrequently pelvic organs are removed for the relief of pelvic pain when the cervix is primarily responsible for the symptoms. A healthy cervical stump may frequently become diseased long after hysterectomy.

Symptoms resulting from a diseased cervical stump are usually multiple and are pelvic pain, leukorrhea and/or bloody discharge, dyspareunia, backache and bearing down pain.

In 11 of the 16 cases in this series the condition was sufficiently pathologic to warrant extirpation of the cervical stump. Any case evidencing vaginal bleeding warrants a thorough study to rule out carcinoma.

All but one of the retained cervices necessitating removal were extirpated vaginally, and there was no mortality. Thirteen patients were followed long enough to evaluate results. Ten had complete relief, 2 partial and 1 no relief.

The only hysterectomy that should be done in this day and age, except in extenuating circumstances, is a total hysterectomy. In properly trained hands there should be no difference in mortality and morbidity between total and subtotal hysterectomy.

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General Practice and Urology with a Commentary on Educational Trends in Medicine, Past and Present

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The general practitioner of today has fewer frustrations and a wider scope than did his brother of yesteryear. How? Well, if the calendar has not slowed him down, he has enjoyed and is enjoying better educational methods as an undergraduate, greater opportunities for internships, residencies, refresher courses, vastly improved diagnostic aids, less didactic and more bedside instruction, and a group of therapeutic agents of which his forbears never dreamed. These significant advances, however, impose upon the general profession added responsibilities.

In colon bacillurias of children for example, it is not sufficient to render the urine of a child free of colon bacilli; one should follow such cases to their logical conclusion. It has been established that a not inconsiderable number of these cases have a background of anomalies which may easily be disclosed by intravenous urogram following a scout film. This will delineate congenital defects as well as excessive renal mobility, especially detectable by upright position with deep inspiration, renal pelvic defects, rotation of kidney with angulation of the ureter, obstruction by aberrant blood vessels, et cetera. When anomalies are encountered, one should search for other abnormalities; they frequently come in pairs. Moreover, a scout film is one of the best indicators of intestinal status. Roentgenologists will doubtless confirm this statement. It is a well known fact that in the years gone by, and doubtless today, some of these children infected with colon bacilli have been permitted to reach adolescence when such state of affairs has been disclosed, which should have been uncovered in early childhood.

The pediatrician should also know and doubtless does, that extrophies become promptly infected, and if intervention is too long delayed, they meanwhile continue their menacing effect on the upper part of the urinary tract. After all, the bladder is the reservoir of end products, a rubber ball with a fixed base. In this organ nature has constructed the greatest of all receptacles, with a flexibility in expansion and notification to its host of when to empty itself and prepare for the next filling from above. In the presence of nature's failure here as in extrophy, operative intervention should be undertaken much earlier than is now generally the rule.

Here again, intravenous urography is once more the diagnostic key. In hematurias, roentgen and endoscopic studies are preferably undertaken when there is macroscopic hematuria. Yes, even infants support such studies. There are suitable instruments available to the urologists for any case and any age. I present here an infant catheterizing endoscope No. 10 F. caliber (about the size of a small catheter) which gives adequate vision and carries a No. 3 ureteral catheter. It is also provided with a real catheter deflector, the first on any instrument of its type within my ken.

Dr. Samuel Kramer, of my staff, has a boy 11 years old, in the Polyclinic Hospital at the moment of compilation of this paper. He was admitted

Read before the Staff of the New Mt. Sinai Hospital of Greater Miami, Miami Beach, April 3, 1950.

with acute retention from prostatic hypertrophy. My associate performed an endoscopic resection on this child. Yes, we have a resectoscope adaptable for such a patient; a No. 16 F. resectoscope that was used is here presented. A preliminary external urethrotomy was necessary in this case. I wish to present also a No. 12 F. resectoscope shown for the first time. You will see, therefore, that any pathologic entity at any age, along the course of the genitourinary tract, can be clarified and corrected with precision by your urologic colleagues.

Maldescent of a testis is another condition frequently fumbled because of the fallacious belief one should wait some time. Early intervention in this condition is or should be a must. Why wait?

You have already noticed my predilection for intravenous urography. Do not, however, misconstrue my attitude on intravenous urography. I place it in the same category with the stethoscope in conditions of the chest. Generally speaking, its use serves as a preliminary to roentgen study; so too urography is a general preliminary to pyelography. Every physician should be equipped with x-ray apparatus.

You will also note that this talk is not intended to be encyclopedic in character; the rationale is to use illustrations as they occur to me to highlight the general theme. While on this subject it may seem elementary to state that no two arms of patients are alike and that anesthetists and residents, with but few exceptions, treat the arm veins or lack of them too casually. Without any attempt to fill the veins they place the arm on a rest, the result not infrequently being three to a half dozen punctures. Unless the veins are prominent and obviously easy to enter, the arm should be placed in a pendant position, and the patient instructed to open and close the fist while in this position. When the veins are thus filled, light compression is begun and maintained; too heavy compression may produce paresis of the walls of the vein. I always use a hypodermic needle and interrupt the injection from time to time. At the moment, our preference is for neo-iopax 75 per cent solution, from which I have yet to observe even minor reactions.

A boy aged 6 came under our observation a good many years ago, with a congenital absence of one kidney; the solitary kidney was hydronephrotic and the lower end of the ureter was stenosed for about a third of its trajectory. How the boy lived his short six years perplexed all of us. We settled, however, for a nephrostomy. He lived to the age of 20, meanwhile carrying the nephrostomy tube, developed into a husky chap and played football on his high school team. After fourteen years he returned, obviously uremic. We passed a panendoscope through the renal sinus and found the renal pelvis lined with tenacious crystalline material. Blood chemistry findings were bad. The boy was cared for by his father, under instructions, and because of his obvious good health, we saw him at rare intervals. Had he been under continued observation, it might have been possible with biochemical examination of urine, or stray crystals, to regulate the hydrogen ion content of the renal output and by means of pelvic lavage through the sinus and regular endoscopic inspection of the renal pelvis, to obviate such a termination — who knows? Was there remissness on the pediatric side or was the fault that of the family doctor? Intravenous urography would have brought the child into the hospital years earlier.

Enuresis

Children and occasionally adults suffering from enuresis may have as background one of the many and varied etiologic factors: glandular dyscrasias, vitamin deficincies, environmental influences and nervous stigmas; locally, any irritative factor along the urinary tract trajectory, phimosis, et cetera. After all, it is frequently an irritative precipitancy. Answer — find the underlying factor, which is not so easy; constitutional, thyroid, tonsils, sinuses, et cetera. Biochemistry consists of bacteriologic study of the urine from a sterile catheterized specimen and determination of the hydrogen ion content of the urine. Make this test yourself with nitrazine paper. Ascertain the capacity of the bladder, make an endoscopic inspection for pathologic change in the vesical neck, hyperplasia of the verumontanum, papillitis of the same structure, and cystic degeneration at the vesical neck. Verumontanum therapy consists of topical application of a 10 per cent solution of silver nitrate. Papillitis of the verumontanum requires electrocoagulation. The history is of the utmost importance. A girl aged 12, suffering from this condition, was accustomed to spend her evenings listening to "Westerns" on the radio until she fell asleep. Her father said they even made him jumpy.

Suggestion to Obstetricians

It may seem trite to suggest the most complete inspection of the newborn infant. An illustrative case reveals that it is not so elementary. Phimosis and atresia of the meatus, both present in this infant and overlooked, occasioned the destruction of both kidneys. Casualness or a cursory survey may bring grief to the parents and confusion to the doctor. While it is not altogether too easy to determine urinary output in an infant, it is possible to estimate retention by means of palpation and percussion of the bladder, or transilluminations. This examination may indicate the advisability of more specific investigation.

Urinary Disturbances in Pregnancy

In early pregnancy the obstetrician should go into the prior history of his patient. When a history of previous genitourinary disturbance is reported, he should have the condition determined by intravenous urography and cultural study. Retrograde urography here, according to Stanley Woodruff, is unobjectionable. When such disturbance supervenes during pregnancy, it should be determined and, when possible, corrected. As a matter of fact, this subject was first reported over one hundred years ago. Woodruff, in 60 unselected cases, found right ureteral and pelvic dilatation (ureterectasis or pyelectasis) in 56 of the 60 cases studied and nephroptosis in 25 per cent of these cases.

Calculous Disease—A Personal Commentary

While it is probably true that metabolic and biochemical processes play a role in the composition of calyceal, renal pelvic or ureteral calculi, the basic underlying factors are obstruction, infection and surface characteristics. It is my belief that much academic hokum has been written around dietetic regulation in the prevention of recurrent calculi. Few patients will carry out for any length of time some of the rigid diet restrictions outlined for them. At all events, I have yet to observe a case in which diet per se has by itself effectively prevented such recurrence. Much of the urinary tract is a sewage system; its chief function is drainage of end products. It is not enough, therefore, to remove a stone at operation. The kidney must be suspended and the observation made at the time of operation that it is restored to such a position, a pendant one, so that any angulation of the renal pelvis or upper part of the ureter is corrected. Moreover, stricture at the ureteropelvic junction should be ruled out, or corrected as much as possible, at the time of operation. Then too, any renal pelvic infection should be predetermined and postoperatively followed by ureteral dilatation and renal pelvic lavage, when indicated.

Postoperative urologic checkup should be carried out at regular intervals. If residual infection is present, the specific bacteria are or should be known, and such new agents as penicillin and aureomycin will be most effective, not only constitutionally, but also by renal pelvic lavage. As hitherto carried out, the contact of these agents, intrarenally and pelvically, has been fleeting and empiric. One should first predetermine the renal pelvic and calyceal capacity and then introduced the ureteral catheter bag here presented; fill these cavities to such capacity and maintain contact of the agent with all the interstices for a given period of time. This then is offered as a rationalized modern method for the prevention of recurrence of renal or ureteral calculi. Finally, as this bag may be constructed tough enough to serve a purpose in withdrawal of moderate-sized ureteral stones, it has the added advantage that if it becomes stuck anywhere along its trajectory, the bag may be deflated and withdrawn. A preliminary to this measure, however, is the dilatation of the proximal part of the ureter.

Fulminating or Obstructive Uremias

This report of a case will prove the duodenal tube one of the most valuable instruments in all urology. The patient entered the hospital with a history of renoureteral calculus. He entered the medical department where for some unknown reason a gastrointestinal roentgen study was made. Later he was referred to the urologic department, where a ureteropyelogram was carried out with negative findings. Following this step, acute suppression of urine occurred. For three days the output was 6 ounces, 4 ounces, and 3 drachms. The usual methods were exhausted without result. At a round table consultation, the duodenal tube was suggested, and on a hunch, its use was immediately inaugurated. First, a complete flushing was begun with large doses of sodium sulfate; next, grand intestinal lavage with tap water, after which feeding through the tube on a caloric base. This regime was continued for three days, and in the following

twenty-four hours, the patient secreted 2,100 cc. The tube was removed, but a day later the patient again had convulsions, and the tube was replaced. After a few days he passed an agglutinated mass of uratic calculi, and from this point made a complete recovery. The diagnosis was uratic calculus, with obstruction of one side and reflex anuria of the other. This experience has been repeated in a number of cases since that time, from other uremias, but none so dramatic.

At Boca Raton last March, before the Southeastern Urological Association, I presented a visualized ureteral forceps, as a matter of record. Some further improvements will have to be carried out on this instrument before we will consider it a fait accompli.

Hematurias are a red light on the track. The general practitioner should recognize this fact. He should also know that most hematurias are intermittent, that he does his patient an injustice in assuming the patient should be kept under observation just because the bleeding has ceased. He should promptly subject his patient to a complete urologic survey. Moreover, he may easily make a good snap diagnosis by noting, is the hematuria initial, total, or terminal; is it accompanied by dysuria, or is it painless? Initial hematuria may be urethral or prostatic; painful hematuria with frequency, especially nocturia, in a young male subject is probably tuberculous. Total, intermittent, painless hematuria generally indicates vesical neoplasm; if accompanied by dysuria, it is apt to be malignant; if affected by movement, calculous disease may be the factor; if accompanied by ureteral casts, hypernephroma. Finally, there is the Papanicolaou stain for centrifuged urine. All this should interest the practitioner.

For tumors of the bladder we have found that the reflectoscopic telescope will give a comprehensive knowledge of many of these growths hitherto unattainable, both for visualization and therapy. It is a foreoblique lens system with attached mirror which can be elevated at will, and so enables the observer to see the growth from all sides.

Concerning Operative Procedures on the Prostate

At no time have I assumed that prostatic resection was the panacea. I have always believed that open operation was still with us and, until the hormonal era has arrived, will continue to be a most useful operation in properly selected cases. In fact, there is already a renaissance of one stage suprapubic prostatectomy with or without complete closure of the bladder. Concerning complete closure of the bladder, I see no gain by such a step. Following open operation, every patient should be kept under observation for at least two weeks, lest he overestimate his strength. My thought is that the bladder incision should be closed but before one does so, a counteropening is made in this organ, sufficient to admit snugly a 24-26 right angle whistle tip catheter. This may be removed after two or three days. A urethral catheter takes care of the drainage thereafter. It is assumed, of course, that vas ligation has been done in all such cases.

An interesting observation here is that some years ago I reported what I considered a rational method of arresting the usual hemorrhage following removal of the prostate gland. It is transurethral visual electrocoagulation of the bleeders. Because I could not sell the idea to some of my associates, we did not follow through to the point of sufficient clinical background for confirmatory reporting. Now, Dr. Abraham Hyman comes along with a report of 30 cases done by this method, with complete closure, with one fatality, of coronary origin. Complete healing in seven days occurred in 1 case, and the average was ten or eleven days. Here then, is what appears to be a new and more promising precision approach to this operation. It is my thought that something may be lost and little is to be gained by complete closure. In such cases one should comply with the building laws — always leave a fire exit.

Some Thoughts on the Management of Bladder Tumors

At the moment, tumors of the bladder are treated endoscopically, by resection or cystectomy; I almost forgot roentgen rays and radium. Let us consider roentgen rays and radium, or both. Some time ago, I received a letter of inquiry from Professor Bruni of Naples, Italy, asking my opinion about "contact x-ray treatment of cancer of the bladder." My answer was about as follows: It is to be hoped that my convictions on this subject will not ruffle too many Italian urologic feathers when I say that I regard the use of either or both of these agents in the treatment of cancer of the bladder as an abomination; that we have used roentgen rays and radium under the guidance of physicists and to their complete satisfaction; that the results of our joint observations have been that

we see no occasion for commendation but much for condemnation; that if the occasional and highly doubtful cure is matched against the misery, the tortures, the early and rapid metastasis, radium and roentgen therapy for this condition would long since have been declared clinically bankrupt.

That endoscopic methods are effective for benign growths in accessible locations in the bladder is definitely established. When, however, they are situated on the superior or posterior wall of the bladder, open operation is better. For infiltrating growths generally single, subtotal excision is to be preferred. For papillary growths, malignant or benign, complete mobilization of the bladder is indicated when the growths are situated as described. When so mobilized, a laparotomy pad is interposed between the bladder and subjacent structures; one can then do a subtotal excision when feasible. When multiple, however, one can do a real job on such growths with electrical excision, when they are situated on the rubber ball part of the bladder. If it occurs on the trigone, the growth can be excised down to the musculosa and the base electrocoagulated in a manner impossible with endoscopic methods. In a case of ours, a patient so treated two and a half years ago, with six discrete papillary adenocarcinomas, is today cystoscopically and symptomatically free of any evidence of his disease. It seems to me there are altogether too many ureterosigmoidal anastomoses.

Instrumental Exploration of Seminal Vesicles

The majority of urologists brush off the subject of instrumental exploration of seminal vesicles with a shrug of the shoulders. If these gentlemen are content to leave this, the last urologic structure to emerge from the field of empiricism, in the obscurity of the "gay nineties," they are not completely equipped urologic technicians. Such men as Herbst of Chicago, who has really focused his attention on this subject, have done a first class job in this field. After all, it is a potential focus of infection. A few technical points may be of interest. If the verumontanum is edematous and irregular, a few topical applications of a 10 per cent solution of silver nitrate will bring it back to normalcy. One then should use the smallest possible bougies for preliminary duct dilatation, first softening the end of the bougie by dipping it in hot water. When ducts are thus found patent, a No. 3 or small No. 4 ejaculatory duct catheter is employed. Then one collects a specimen for culture by injecting a small amount of sterile salt solution, which will start return flow. Herbst advocated caudal anesthesia as a preliminary to prevent spasm of Bell's muscle.

Finally, seminal vesiculograms are frequently informative. Years ago, we collected normal ejaculate which our biochemist, Dr. John Killian, placed in incubators, diluting it with buffer solution of phosphate and glucose solution. This was then injected into azospermic vesicles, and after forty-eight hours, we withdrew normally active spermatozoa, but accompanied by blood and pus cells. It was not then possible to sterilize the mixture without damage to the sperm. Today, some of the newer antibiotics may be capable of solving this vital question.

I could not come to the Southland without a comment on perineal prostatectomy. One thing is certain, that the perineal method is the one approach to the calculous prostate. It is superior to resection and in my opinion, the subtotal removal is not as a rule necessary. Aside from this I prefer the suprapubic approach. The methods generally recommended for perineal prostatectomy are not based on sound anatomic principles. My own suggestion is first to pass per urethra a Foley catheter which is provided with a small flexible bougie; one can thus by palpation easily trace the urethra. Once beyond the bifurcation of the levator muscles, one arrives by blunt dissection at the prostatic urethra. This is facilitated by traction on the Foley bag. The prostatic urethra is now opened transversely posterior to the verumontanum. The Foley bag is now deflated and withdrawn, and a traction bag, such as was used by Parker Syms years ago, is introduced through the perineal incision on a strong stylet, and inflated. With this bag one then exerts traction which brings the prostate well into the field in a symmetric manner, and because it is flexible, the finger may be forced into the prostatic urethra and the enucleation of the prostate carried out in a manner identical with that of suprapubic enucleation (intraurethrally). This bag is superior to the metal retractors in general use. By this procedure both sphincters remain continent as can be proved by urethrocystogram.

Finally, I wish to present a definite advance on the popular panendoscope. It is a simple and long-needed deflector regulated from without. This

instrument, presented for the first time, will in my opinion replace all other cystoscopes; at least, it has met with the unanimous approval of my tough departmental associates. Once a development obtains such acceptance, I can face the outside urologic world with equanimity.

My congratulations to Dr. Charles Lippow and to your officials for so discriminatingly honoring him. Dr. Lippow has been a valued member of my department at the New York Post-Graduate and New York Polyclinic hospitals for many years. It has, therefore, been a pleasure to interrupt my vacation for him, and my privilege to have the opportunity of addressing you. In conclusion, my best wishes go out to you for great public service.

2 East Fifty-Fourth Street.

ABSTRACTS OF MEDICAL ARTICLES

CYSTIC HEMANGIOBLASTOMAS OF THE CEREBELLUM, END RESULTS IN 25 VERIFIED CASES. By Irwin Perlmutter, M.D., Gilbert Horrax, M.D., F.A.C.S., and James L. Poppen, M.D., F.A.C.S. Surg., Gynec. & Obst. 91:89-99 (July) 1950.

The authors present a series of 25 cases of cystic hemangioblastoma of the cerebellum treated surgically in which 17 patients are entirely well and 5 others improved from one to fifteen years following operation. There were 2 operative deaths, and 1 patient died subsequently. Among the last 19 patients operated on since 1937, however, there were no operative deaths. The series represents practically 2 per cent of a total of some 1,300 brain tumors verified at the Lahey Clinic over a fifteen year period.

Historical notes, familial incidence, pathologic features and surgical treatment are discussed, and the series is analyzed with discussion of the gross pathologic features and microscopic appearance of the tumors. The average age at onset of symptoms was 34. A familial relationship was demonstrated in 16 per cent of the cases, and the same figures obtained for the incidence of von Hippel-Lindau disease. In 20 per cent, a relationship of trauma to onset of symptoms was determined.

In view of the familial character of cerebellar hemangiomatous cysts and their frequent association with angiomas of the retina, the authors stress the necessity of a careful history on this score as well as an ophthalmoscopic examination with the pupils dilated in all cases of suspected cerebellar tumor. They observe that the hemangiomatous cysts as well as the astrocytomatous cysts of the cerebellum are the most favorable of all intracranial tumors because after evacuation of the cyst and complete extirpation of the solid tumor or mural nodule the patients are almost invariably completely free of residual symptoms or troublesome sequelae.

TRACER STUDIES OF THE URINARY EXCRETION OF RADIOACTIVE MERCURY FOLLOWING ORAL ADMINISTRATION OF A MERCURIAL DIURETIC. By William J. Overman, M.D., William H. Gordon, Jr., M.D., and G. E. Burch, M.D. Circulation 1:496-501 (April) 1950.

This report presents experimental evidence of the inefficient intestinal absorption of mercury following the oral administration of standardized single doses of plain and enteric-coated capsules of a mercurial diuretic. Radiotracer technic was employed using a diuretic prepared with radioactive mercury. Both the 22 control subjects and the 5 subjects with chronic congestive heart failure were shown to absorb only a small percentage of the mercury administered by the oral route.

The authors concluded that the observations of poor absorption, low blood concentration, and low urinary excretion of mercury following oral administration of this mercurial diuretic preclude its general use in the treatment of chronic congestive heart failure.

INVESTIGATION OF OCCUPATIONAL DERMATOSES IN THE CITRUS FRUIT CANNING INDUSTRY. By Donald J. Birmingham, M.D., Paul C. Campbell, Jr., M.D., Henry N. Doyle, B.S., and J. M. McDonald, M.D. A. M. A. Archives of Industrial Hygiene and Occupational Medicine 3:57-63 (Jan.) 1951.

During January 1947 the Division of Industrial Hygiene, United States Public Health Service, in cooperation with the Division of Industrial Hygiene of the Florida State Board of Health, conducted a survey of the Florida citrus fruit-canning industry to determine the incidence, the causes and the means of preventing occupational skin diseases among the workers in that industry. The study was conducted in 11 typical plants, and about 1,200 employees were examined.

Various forms of occupational skin disorders were observed in workers in every plant visited. They consisted mainly of contact dermatitis, onychia, paronychia, burns and callosities of the palms, erosio interdigitalis blastomycetica and knife blade lacerations.

Patch tests made with grapefruit and orange pulp and juice gave results which coincided with those of previous studies, namely, that in the majority of cases "citrus dermatitis" does not occur on the basis of specific sensitization.

Recommendations for preventing occupational dermatitis among cannery workers are listed.

HUMIDITY, ITS RELATION TO PROBLEMS OF DERMATOLOGY. By Wiley M. Sams, M.D. South. M. J. 44:140-148 (Feb.) 1951.

Dr. Sams offers an interesting study of physical factors in relation to disorders of the skin. He presents clinical data concerning the association of miliaria rubra and certain infections of the skin, notably, impetigo and ecthyma, furunculosis and carbuncle, and moniliasis and tinea versicolor. He concludes that a mean monthly temperature of 80 F. and a mean monthly dew point temperature of 70 F., combined with a relatively low wind speed (9 miles per hour) are conducive to the development of these common skin disorders when such conditions exist for a period of two weeks or longer. The effects of such climatic conditions are cumulative in his opinion, and they present special problems in the diagnosis and treatment of a number of skin diseases.

DIAGNOSTIC ASPECTS IN 300 KNEE INJURY CASES. By Herbert W. Virgin, Jr., M.D., F.A.C.S. South. M. J. 43:1017-1023 (Dec.) 1950.

In reviewing this series of cases from his private practice, Dr. Virgin considers the fact that there are more diagnostic entities involved in cases of knee injury in private practice than one would ordinarily expect. His tabulation shows 46 such entities. He concludes that one should not diagnose everything as cartilage damage, for one may encounter many rare diagnoses, and also that a diagnosis must not stop on the examining table but be continued upon the surgical table. He describes the manner in which he has modified and enlarged the McMurray test so that it has become about 90 per cent effective in diagnosing semilunar cartilage injuries of the knee joint.

PLACENTA ACCRETA WITH VELAMENTOUS INSERTION OF THE CORD, REPORT OF A CASE TREATED BY HYSTERECTOMY FOLLOWING NORMAL DELIVERY. By Robert E. Blount, M.D., and L. U. Lumpkin, M.D., F.A.C.S. South. Surgeon 15:411-416 (June) 1949.

These authors report a case of placenta accreta with concomitant velamentous cord insertion which demonstrates the accepted method of dealing with this rare and extremely dangerous complication of pregnancy. They recognized the condition at once and resorted to immediate abdominal hysterectomy, the treatment of choice in all such cases.

In this case already complicated by placenta accreta, by which is meant abnormal adherence of the entire placenta or part of it to the uterus wall with partial or complete absence of the decidua basalis, the velamentous cord insertion represents a second complication. The authors found no other such double abnormality reported in the literature.

They reached the following conclusions: (1) Placenta accreta occurs in multiparae in the second and third decades of life. (2) The predisposing factors are previous manual removal of placentae, or other traumata to the endometrium. (3) Early recognition of the existence of the condition is of primary importance. (4) Once the diagnosis is established, immediate replacement of blood loss by transfusion followed by supravaginal hysterectomy is the recognized treatment in placenta accreta.

WILMS TUMOR, AN ANALYSIS OF 39 CASES SEEN AT DUKE HOSPITAL IN THE PAST 18 YEARS. By David W. Goddard, M.D. South. M. J. 43:906-909 (Oct.) 1950.

The series of 39 cases of Wilms tumor reported by this author, 37 of which were followed, includes all of the cases of this dread disease observed at Duke Hospital over a period of eighteen years. In nearly 90 per cent of these cases the disease occurred in children whose ages ranged from 1 through 7 years, and white children outnumbered Negro children 2 to 1. The over-all mortality was 78.4 per cent. As a result of this experience and the published experience of others, these principles of treatment now are followed: all patients operated upon are given postoperative roentgen therapy; in most inoperable cases the patients are given palliative roentgen therapy; only those candidates for operation whose tumors are too large to remove without definitely increasing the operative risk are given preoperative roentgen therapy. The high casualty rate clearly indicates the need for early diagnosis and definitive treatment, Dr. Goddard concluded, with, perhaps, closer and more thorough cooperation between the x-ray therapist and the urologist in the clinical management of these problems.

THE INCIDENCE OF RHEUMATIC HEART DISEASE IN NATIVE SCHOOL CHILDREN OF DADE COUNTY, FLORIDA. By Milton S. Saslaw, M.D., Bernard D. Ross, M.D., Ph.D., and Max Dobrin, M.D. Am. Heart J. 40:760-765 (Nov.) 1950.

The survey presented in this article represents a systematic investigation performed to determine the incidence of rheumatic heart disease among 1,001 school children from 10 through 16 years of age, born and reared in Dade County. These children were selected at random and included 348 white boys, 231 white girls, 198 Negro boys, and 224 Negro girls. The incidence of 5.0 children with rheumatic heart disease in this series is similar to that found in other surveys performed by the same method in areas having a mild subtropical climate, notably Southern Arizona (5.0 per 1,000) and Redlands, Calif. (3.8 per 1,000), and is of a smaller magnitude than that found in more northern localities.

USE OF HYALURONIDASE WITH LOCAL ANESTHETIC IN TONSILLECTOMY. By C. J. Heinberg, M.D., F.A.C.S. Eye, Ear, Nose & Throat Monthly 30:31-32 (Jan.) 1951.

The use of Hyaluronidase in many surgical procedures led Dr. Heinberg to investigate and evaluate its use in otolaryngology. He concluded that it is a safe adjunct to solutions used for local anesthesia in tonsillectomy and in other surgical procedures. Rapid diffusion enables the surgeon to begin the operation immediately after injection, he observed, and to use less volume; healing is not retarded, and there are no untoward reactions either local or general.

A SIMPLE ROTATABLE ELECTROTOME. By James J. Nugent, M.D. J. Urol. 64:534-536 (Sept.) 1950.

A model is presented of an electrotome which is rotatable and provides direct tactile control of the cutting loop. It is streamlined, highly insulated, and simple in construction, utilizing many existing parts.

DACRYOCYSTORHINOSTOMY: THE EXTERNAL APPROACH. By Marion W. Hester, M.D. South. M. J. 43:766-769 (Sept.) 1950.

Dacryocystorhinostomy, long regarded as a difficult and lengthy operation, especially by ophthalmologists, need be neither difficult nor lengthy, according to Dr. Hester. He presents the history of the development of this operation and describes the indications and counterindications. After reviewing the most commonly used methods, he describes the Dupuy-Dutemps procedure, probably the most widely used of all tear sac operations. He also summarizes the results in several series and discusses the causes of failure.

His conclusions are: (1) Dacryocystorhinostomy is preferable to dacryocystectomy except in rare instances. (2) The operation is successful in a high percentage of cases when properly done by any one of several methods. (3) Consistently more successes are reported when sutured mucosal flaps are used. (4) The operation can be performed by any capable eye or ear, nose and throat surgeon.

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VOLUME XXXVIII
NUMBER 1

The Journal of the Florida Medical Association

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July Anniversaries

JULY 1. The Royal College of Surgeons of Edinburgh, chartered on July 1, 1505, actually was a union of barbers and surgeons. The charter required that the licentiates be freemen of Edinburgh, that they be examined by the officers of the college as to their knowledge of anatomy, particularly in regard to veins and phlebotomy, and that they be able to read and write. A criminal's cadaver was granted them each year for dissection.

In England, the corporation of surgeons was not separated from the barbers until 1745. The barbers' guild, however, continued to flourish, and it was not until 1800 that the Royal College of Surgeons received its charter.

JULY 4. William Crawford Gorgas of Mobile, Ala., was born on Oct. 3, 1854 and died on July 4, 1920. Soon after Walter Reed and his associates in 1900 had established the mosquito as the vector of yellow fever, Gorgas, a member of the Medical Corps of the United States Army and sanitary officer of Havana, rendered that city yellow fever-free for the first time in a century and a half. Even more far reaching and just as spectacular was Gorgas' work in the Canal Zone. In a relatively short time, despite obstructions by his military associates, Gorgas changed what was known as the "White Man's Grave" into a healthful region. Later he served as surgeon general. Before he died, he was recognized as the world's foremost authority on sanitation. In 1951, he was elected to the New York Hall of Fame.

JULY 7. On July 7, 1348, more than 600 years ago, the most terrible of all epidemics is supposed to have reached England at Weymouth, then called Melcombe Regis. Having crossed the Crimea and the Black Sea to Constantinople, having entered Egypt via Mesopotamia and Arabia, having invaded almost all of Southern Europe by 1347 where it fell with frightful violence on Sicily, Italy and Southern France, it spread through Holland to England on the one hand and to Germany, Poland and Russia on the other. Known as the Black Death, the bubonic plague "came more nearly to extirpating mankind than any other evil." More than half the priests of Yorkshire, two thirds of the students at Oxford and between a quarter and a half of the people of all England are said to have perished. Boccaccio's "Decameron" remains a classic today not only because it presents an eloquent picture of the devastated cities of Italy, but also because of the accurate account of sanitary measures which were established at that time.

JULY 8. Benjamin Waterhouse of Boston probably was the first to practice smallpox vaccination in the United States. He vaccinated four of his children on July 8, 1800, and later exposed them to the disease. They remained well.

JULY 12. The New York Hospital, now combined with the Cornell Medical School as one of the truly outstanding medical centers of the world, was chartered on July 12, 1771. Before the original building was completed, it was destroyed by

fire; during the Revolutionary War the British used the hospital building as barracks for the Hessian troops; later the building was used as the meeting place for the New York state legislature and for instruction of Columbia College medical students. Since 1791, the hospital has been used almost exclusively for its original purpose. The New York Hospital, the Philadelphia General Hospital starting as the Infirmary of the Almshouse in 1731, the Bellevue Hospital of New York starting in 1735, and a combined Hospital and Almshouse in New Orleans opening in 1737, offered opportunities for clinical instruction in medicine which prior to that time had to be obtained abroad. Thus the groundwork was laid for the establishment of medical schools in the United States.

July 15. On July 15, 1662, the Royal Society of London was chartered, the beginnings of which date back to 1645. Minutes recorded in 1660 state that the reason for founding the college was to promote "physicomathematical experimental learning," and the whole emphasis was on experiment. Correspondence with "philosophers" on the continent of Europe included reports from such men as Leeuwenhoek and Malpighi published as early as 1664. In 1686, when Samuel Pepys was secretary, the society sponsored publication of Sir Isaac Newton's "Principia."



Theobald Smith

July 31. Theobald Smith was born in Albany, N. Y., on July 31, 1859. A real pioneer, Dr. Smith was the first to show that filtrates of the bacillus of hog cholera conferred immunity on injected animals. His demonstration in 1899, that the cattle tick was the cause of Texas cattle fever, was an important early step in the recognition of insect vectors in disease. In 1903, he called attention to anaphylactic shock in experimental animals, which later Ehrlich named "the Theobald Smith phenomenon." This actually led to the subspecialty "allergy." Dr. Smith also was the first to differentiate between the human and bovine types of tubercle bacilli. Long in the service of the federal bureau of animal industry, later professor of comparative pathology at Harvard, and still later director of the department of animal pathology at the Rockefeller Institute for Medical Research, Theobald Smith was unpretentiously devoted to truth. Said he: "Discovery should come as an adventure rather than as the result of a logical process of thought. A fact is worth more than theories . . . the theory stimulates but the fact builds."

"A Minting of Clearcut Wisdom"

Dr. D. J. McCarthy of Philadelphia and West Palm Beach is this year serving as Honorary Chancellor of Florida Southern College at Lakeland. A long time member of the faculty of the University of Pennsylvania School of Medicine, this distinguished physician, educator and art collector comes to this position at a time when important educational history is in the making there. Appreciating the pioneering spirit at work in this college, as evidenced on its campus by the unique architecture of Frank Lloyd Wright design, Dr. McCarthy is lending his influence and support to a new and timely architectural project of the mind and of the spirit.

Physicians of Florida and of the nation, who are already having their baptism of fire in the front line trenches of the fight for freedom, will learn with interest of a long range constructive step, the first of its kind, now becoming a reality at Florida Southern in the form of a Chair of American Culture. This new department will be devoted to the fullest possible appreciation of what we have come to call the American way.

As an Independence Day reflection, we may well ponder and deplore the tendency of the American people to discount their own culture. Although surrounded by this rich and hard won culture, most of us neither recognize nor appreciate it adequately. If we did, we would keep it inviolate, invincible, wholly impervious to the inroads of alien doctrine and propagandistic persuasion. And in today's world, we need as never before to understand and enhance our American culture. But to understand it, we must define it.

So reasons Florida Southern's President Ludd M. Spivey, who aptly defines this culture in these words: "Our culture then becomes our attainments and aspirations motivated by our moral insistence upon the freedom of the individual, worth of the individual and respect for the individual."

It is the nation's youth who must be the guardians of our freedom. What worthier objective could education have than to provide them with the ways and means whereby they can absorb and subsequently disseminate the culture of their land?

In the words of the eminent journalist, Charles Francis Coe, commenting editorially in the Palm Beach Times, here "is a minting of clearcut wisdom. A program responsive to the greatest need of our time. . . .

"Included in that word culture, we assume, is the American Philosophy of Government addressing itself to Human Freedom, Human Dignity, the right to Individual Liberty, the Supremacy of the Human Soul over governmental institutions of its own creation.

"Many call it The American Way. Not alone would the college teach that culture, it would implement that teaching by the why and the wherefor. . . .

"We speak solely as a devoted American. We speak as a citizen finding at woefully retarded date, a practical plan which hits the target dead center. . . .

"It would be particularly fitting that a college in the Deep South should bring forth the pattern so sorely needed for our students. From the depths of a fine tradition, thus would recrudesce a purpose glorified. . . .

"At long last, an American college has set out to rediscover America and spread its imperishable institutions before the eager minds of American Youth.

"God bless that purpose. God prosper the men pursuing that purpose."

Pamphlet Disseminating Un-American Philosophy Withdrawn

"Social security and public assistance programs are a basic *essential for attainment of the socialized state* envisaged in democratic ideology, a way of life which so far has been realized only in slight measure." At this crucial time when the subject of socialization is much in the public mind, this extraordinarily frank disclosure of aims and astounding objective of democratic ideology is truly noteworthy. It seems hardly necessary to state that it emanates from Oscar Ewing's Federal Security Agency. It is found, to be exact, on page 7, chapter 4, of a pamphlet entitled "Common Human Needs," issued by Mr. Ewing's "Bureau of Public Assistance."

President Elmer L. Henderson of the American Medical Association in his monthly message on The President's Page of the Journal of the American Medical Association of March 31, 1951, directed attention to this directive, currently being distributed at that time. The Federal Security Administrator promptly denied responsibility on the ground that the pamphlet was written and issued in 1945, some two years before he acceded to his present post, and declared it was not a directive, nor was it being distributed currently. He acidly demanded retraction.

It so happened, however, that Dr. Henderson was able to enlighten him regarding the workings of his own agency. The pamphlet in question, five copies of which were received by mail at the A. M. A. headquarters that particular week, bore the imprint, "Government Printing Office, 1949," indicating that Mr. Ewing thought well enough of it to have it reprinted in 1949. Replying further to Ewing's telegram of protest, Dr. Henderson reminded the Administrator that, in case he wished to do so, he might well disavow the principles expressed in the pamphlet in a formal statement to Congress, since "as recently as February 26 of this year, it was protested on the floor of Congress as a grave misuse of taxpayers' money to disseminate wholly un-American philosophies."

It seems Dr. Henderson's telegram of April 11, replying to the Ewing protest, was not long in producing results. On April 14, the Federal Security Administrator took it upon himself to announce to press association representatives that publication had been stopped and existing stocks destroyed of a Federal Security Administration publication, "Common Human Needs," containing language to which the American Medical Association objected.

Would that Mr. Ewing and his agency could clarify their concept of democratic ideology and foreign ideology all along down the line and keep each in its proper category. Medicine's crusade against socialization is by no means over, as this single instance of alertness and aggressive action on the part of medical leadership illustrates. So long as socialism continues to remain a basic tenet of the Administration program, there is urgent need to provide Congress with unequivocal evidence from the grass roots level that the people of this country want no part of socialism. Let every member of the medical profession continue to put forth his best efforts in "constructive, personal evangelism," as Dr. Henderson suggests and is himself doing.

American Answers to American Problems

Are we the people of this republic able to face life's problems or are we not? Over and over again we are told that we are not capable of solving our own problems. Repeatedly the self-seeking bureaucrats and advocates of foreign ideologies urge us to turn from the fundamentals on which our nation has grown and prospered. If we were to heed this socialist ballyhoo, we would succumb forthwith to federal domination and resign ourselves to the whims of government-controlled planning boards bent on reducing us to sheer serfdom.

We who have learned what freedom offers — what are we doing to maintain independence and grounds for incentive? Are we truly concerned with each other's welfare? Are we willing to offer help when it is needed? What is the score from the medical standpoint?

The fine relationship between the National Education Association and the American Medical Association was emphasized recently by the meeting of the joint committee of these two organizations which marked the fortieth anniversary of the committee's founding. To its credit are more than forty publications which have vitally influenced school health throughout the country, notably "Health Education," published in 1924 and revised several times. This committee provides the opportunity for medical guidance in the development of principles which serve education leaders in formulating school health policies.

Americans are unquestionably giving an American answer to the problem of health insurance. The dynamic growth of prepaid voluntary health insurance plans offers both a striking example of social progress achieved from the grass roots and an effective reply to the propaganda of the proponents of federally administered socialized medicine. At the present rate, barring government intervention, voluntary health protection benefits should virtually blanket the population within a comparatively few years. The growth of this sound and sensible movement represents "a sturdy determination by the people of this country to stand on their feet, to do a job themselves instead of letting a bureaucracy regulate their private lives."

This strong determination of the people to help themselves runs like a theme song through the reports of the sixth National Conference on Rural Health, held in Memphis late in February. In true American style, the keynote was "Why Wait — Let's Do It Ourselves." A record number of more than 600 attended this gathering, where "the lay person — farmer, teacher and educator — meets on an equal level with the doctor to discuss health problems of mutual interest"— truly a democratic approach.

President Elmer L. Henderson of the American Medical Association described this meeting as "heart-warming stirring proof that Americans still want to, and can, face problems squarely and meet them vigorously on their own initiative." That community health needs can best be solved by the people involved and not by remote control was the message of Dr. F. S. Crockett, chairman of the Committee on Rural Health of the American Medical Association. Said he, "It is becoming crystal clear that health, like salvation, comes from within." Certainly not from Washington, we might add.

These are heartening examples of a free people engaged in working out their own problems in their own way. May this "resurgence of the spirit of the pioneer" go on ad infinitum.

Obstetric Seminar
Daytona Beach, Sept. 10-12, 1951

An Obstetric Seminar will be held at the Sheraton Plaza Hotel in Daytona Beach, September 10 to 12, which is expected to attract several hundred physicians from Florida and also a large number from Georgia and South Carolina. This three day meeting is sponsored by the Committee on Maternal Welfare of the Florida Medical Association and the Bureaus of Maternal and Child Health of South Carolina, Georgia and Florida State Health Departments.

Papers on timely subjects will be presented each morning and on Monday and Wednesday afternoons and Tuesday night out-of-state speakers will participate in round table discussions. Monday night and Tuesday afternoon will be devoted to social and recreational activities, and the concluding event will be the banquet on Wednesday night.

The group of distinguished lecturers includes Dr. R. Gordon Douglas, Professor of Obstetrics, Cornell University Medical College; Dr. Edith L. Potter, Associate Professor of Pathology, University of Chicago, The School of Medicine; Dr. F. Bayard Carter, Professor of Obstetrics, Duke University School of Medicine; Dr. Carl Parker Huber, Professor of Obstetrics and Gynecology and Chairman of the Department of Obstetrics, Indiana University School of Medicine; Dr. Fred L. Adair, Emeritus Professor of Obstetrics and Gynecology, University of Chicago, The School of Medicine; Dr. Richard Torpin, Professor and Chairman, Department of Obstetrics and Gynecology, University of Georgia School of Medicine; Dr. Perry P. Volpitto, Professor of Anesthesia, University of Georgia School of Medicine; Dr. Charles C. Chapple, Associate Professor of Pediatrics, University of Pennsylvania Hospital; and Dr. Warren W. Quillian, President-elect of the American Academy of Pediatrics.

Postgraduate Medical Education

The Thirty-Ninth Annual Clinic and Thirty-Third Annual Meeting of the John A. Andrew Clinical Society were held at the John A. Andrew Memorial Hospital, Tuskegee Institute, Tuskegee, Ala., April 8-13, 1951.

A foreword of greeting from Dr. Eugene H. Dribble, Secretary-Treasurer of the Clinical Society, stated that the midcentury meeting had been planned in accordance with the philosophy of the John A. Andrew Clinic, namely, (1) professional development of the Negro physician; (2) professional interracial contact; (3) professional intersectional relationships; and (4) professional service to the needy sick.

During the five day session, an interesting program was presented by white and Negro physicians from many parts of the United States. Dr. Lucille J. Marsh, formerly of Jacksonville, where she was associated with the State Board of Health, and now Regional Medical Director of the Federal Security Agency (Children's Bureau) in Atlanta, Ga., was among those on the program.

The American College of Physicians is offering a number of attractive graduate courses in internal medicine in the late summer and fall. These courses are intended primarily for its membership, but are open to physicians who are not members of the College if approved by the local member of the Board of Governors. There is an extra fee for nonmembers.

Detailed information may be obtained by addressing the office of the College of Physicians in Philadelphia or Dr. William C. Blake, Citizens Building, Tampa.

In the Educational Number of the Journal of the American Medical Association, issued Sept. 9, 1950, Table 28 constitutes a pertinent study of postgraduate courses offered and attendance for 1945-1950 inclusive, of interest to those planning graduate courses now or in the immediate future.

The total number of courses given for five or more days far exceeds the number of those given for less than five days. Also, the drop from the peak attendance of the shorter courses in 1947 and 1948 was two thirds. The longer courses reached a peak in 1948 and 1949, but the drop for 1950 was not nearly so great. On the other hand, the Clinical Conferences, Graduate Assemblies, Study and Chautauqua Courses have had a consistent increase in attendance.

It is doubtful if any definite conclusion can be drawn from these statistics that would be applicable for any specific locality. Nevertheless, the attendance of the five day courses offered in Florida far exceeded that of the shorter ones.

A further interesting breakdown and valuable information could be obtained if one knew the average number of days each physician attended the five day course. In any event, a five day or longer course well planned seems to be the most attractive. In the case of the American College of Physicians, the one week course was generally preferred to the two weeks course. It would seem that the week's course is the one most desired and the one most appreciated, particularly by the general practitioner.

The Editor Invites Your Contributions On Data of Notable Interest

Pinellas County Medical Society History

To Dr. W. C. McConnell of St. Petersburg, the secretary-treasurer of the Pinellas County Medical Society and the co-ordinator of The Picomeso Mail Bag, official organ of that society, the editors are indebted for a copy of "A Loose-Leaf Cumulative History of the Society." Dedicated to the pioneers in the practice of medicine in Pinellas County, this historical account is of great value, both to the county society whose development it records and to the Association as a whole. In attractive loose-leaf form so that it may be kept up to date, this contribution to the history of medicine in Florida not only deserves warm commendation, but also offers an example to other county medical societies to go and do likewise.

YOUR BLUE SHIELD

Announcement

The Florida Blue Cross and Blue Shield Plans have announced the addition of Frederick MacCurdy, M.D., to their staff. Dr. MacCurdy became connected with the two Plans on May 19 in the capacity of Assistant Director.

The increasing complexity of medical-surgical care and hospitalization, resulting from the steady increase in enrollment in Blue Cross and Blue Shield, and the increased utilization of the coverage of the two Plans, made it necessary for the Plans to secure professional guidance and background for the efficient administration of their contracts.

In addition to being in charge of the Blue Cross and Blue Shields claims departments, Dr. MacCurdy will serve as liaison representative between the Plans and the physicians and hospitals in the state.

Dr. MacCurdy has more than thirty years background in medico-legal work in this country and abroad, having served in various capacities and having headed up several national committees in the medico-legal field. He has also been a hospital administrator and has taught hospital administration at Columbia and New York universities.

Since becoming associated with Blue Cross and Blue Shield in May, Dr. MacCurdy has devoted his time to becoming thoroughly acquainted with all phases of the operations of the two Plans, and is now in a position to assume his offical duties. He will be happy to accept invitations to attend county medical society meetings for Blue Cross-Blue Shield discussions. Physicians are also invited to write to Dr. MacCurdy at Post Office Box 1798, Jacksonville 1, Florida, if there are any particular problems that they would like to have brought to the attention of the Plans.

NEW MEMBERS

Aarons, Edward F., Jr., (Col.), Pensacola
Adams, Texas A., (Col.), Daytona Beach
Barreras, Luis A., Tampa
Essrig, Irving M., Tampa
Gallo, John P., Miami Beach
Grizzard, Vernon T., Jr., Jacksonville
Grove, Helen I., Largo
Herron, Carroll V., Daytona Beach
Isaacs, Ivan, Jacksonville
Juarez, Oscar A., Tampa
Leone, William A., Largo
Long, James A., Jr., (Col.), Palatka
McCorkle, Walter W., Daytona Beach
McSwain, George H., Daytona Beach
Mims, Leon H., Jr., Miami
Moore, Thomas J., St. Petersburg
Neber, Jacob, Miami
Owrey, Robert H., Tampa
Perez, Joseph, DeLand
Powers, Earl J., Orlando
Raybin, George I., Jacksonville
Roberts, Isabel, Melbourne
Seiler, Hawley H., Orlando
Smith, James R., (Col.), Orlando
Sperber, Perry A., Daytona Beach
Stewart, Paul T., St. Petersburg

BIRTHS AND DEATHS

Births

Dr. and Mrs. Grover C. Collins of Palatka announce the birth of a son, Frederick Curtis, on May 13, 1951.

Dr. and Mrs. Millard F. Jones of Jacksonville announce the birth of a daughter, Elizabeth Griffin, on May 9, 1951.

Dr. and Mrs. John T. Karaphillis of Clearwater announce the birth of a daughter, Maria Katherine.

Dr. and Mrs. Kenneth Phillips of Miami announce the birth of a son, William Vernon, on May 4, 1951.

Deaths — Members

Nunnery, Ernest E., Everglades ..... May 2, 1951
Martin, Leon H., Okeechobee ..... May 17, 1951
Roush, Franklin W., Sr., St. Petersburg ..... May 21, 1951
Drew, Horace R., Jacksonville ..... May 28, 1951

Deaths — Other Doctors

Brungard, Otis D., LaBelle ..... Feb. 4, 1951
Jordan, William M., Birmingham, Ala. ..... Feb. 6, 1951
Lamb, Lloyd L., Zephyrhills ..... Feb. 12, 1951
Reiss, George S., Long Beach, N. Y. ..... March 2, 1951
Anderson, Jesse J., Willacoochee, Ga. ..... March 8, 1951
Parks, Walter B., Starke ..... June 10, 1951

STATE NEWS ITEMS

Dr. James L. Borland of Jacksonville, chairman of the FMA Committee on Emergency Medical Service, outlined the medical phase of civil defense on the state level to a group of local women. On June 5, he addressed a section of the women's division of the Jacksonville-Duval County Civil Defense Council.

Dr. James V. Freeman of Jacksonville, chief of the medical service of the local Council, accompanied Dr. Borland on this program discussing the medical aspects of civil defense on the local level.

Dr. George S. Palmer of Tallahassee recently addressed the local Service League. He told of the plans for installing an electroencephalograph in the Tallahassee Memorial Hospital.

Dr. James R. Hanson of Tavares will be temporarily absent from his practice while taking a postgraduate course in electrocardiography at the University of Minnesota Medical School. Dr. Hanson also plans to visit the Mayo Clinic before his return.

Dr. Clarence M. Sharp of Jacksonville, director of the Bureau of Tuberculosis Control for the Florida State Board of Health, was the guest speaker at a recent meeting of the Georgia Public Health Association in Savannah where he spoke on the tuberculosis control program in Florida.

Dr. Lowell S. Selling of Orlando recently addressed the local Kiwanis Club on the work of the Polk County Guidance Center in preventing and reclaiming youth and families from crime.

Dr. Harvey J. Howard of St. Petersburg has announced the publication of his book, "Ten Weeks With Chinese Bandits." The book was written from the experiences Dr. Howard shared as a captive of Chinese bandits for ten weeks during the summer and early fall of 1925.

Dr. Howard is a former professor of ophthalmology at Peking Union Medical College.

Dr. John P. Moore of Ocala recently addressed a meeting of the local colored women's civic clubs on the subject of cancer.

Dr. H. Marshall Taylor of Jacksonville was signally honored by the American Laryngological Association in June when he was elected president at the annual meeting in Atlantic City.

Dr. F. Gordon King of Jacksonville was awarded the degree of Master of Medical Sciences in Surgery by the University of Pennsylvania School of Medicine in Philadelphia on June 13, 1951.

Dr. Shaler Richardson of Jacksonville attended the meeting of the American Ophthalmological Society held in White Sulphur Springs, West Virginia, June 7-9.

Dr. Fred E. Brammer of Dania was guest speaker at a recent meeting of the local Dolphin Camera Club.

Dr. Herschel G. Cole of Tampa recently addressed the local Rotary Club on some of the problems of orthopedic surgery.

Dr. J. Basil Hall of Mount Dora was guest speaker at a recent meeting of the Red Cross Volunteer Nurses Aide in Eustis. He spoke on the responsibilities of the medical leaders of America and their code of ethics.

Dr. Jere W. Annis of Lakeland was the principal speaker at a recent meeting of the local Rotary Club. He spoke on heart disease.

Dr. Leffie M. Carlton, Jr., of Tampa was recently elected vice president of the Florida Tuberculosis and Health Association.

Drs. DeWitt C. Daughtry of Miami and Virgil H. Pieck of Miami Beach were guest speakers at the fourth annual convention of the Florida Society of X-Ray Technicians held in Miami recently. Dr. Daughtry chose for his subject, "Recent Advances in Thoracic Surgery."

Dr. J. Dillard Workman of Live Oak, at a recent meeting of the local Kiwanis Club, discussed the problems of obtaining a medical education.

Dr. William E. Kendall of St. Petersburg spoke of his experiences at the medical mission station in Mayori, Cuba, at the mid-week service of the First Congregational Church of St. Petersburg.

Dr. L. Washington Dowlen of Miami recently addressed the employees of Burdine's department store on the subject of cancer.

Dr. George M. Floyd of Hawthorn was signally honored by his home community in honor of forty-two years of service in that area. Mayor F. W. Webb proclaimed June 10 as Dr. G. M. Floyd day.

Dr. Floyd has practiced in Hawthorn and surrounding territory since June 10, 1909. A native of Abbeville, Ga., he received his medical degree from the Emory University School of Medicine.

Dr. Vernon T. Grizzard, Jacksonville, has returned to his practice following participation in a review course in neuropathology held in Virginia Beach, Virginia, in conjunction with the annual meeting of the American Academy of Neurology, April 11-13. Dr. Grizzard was also in attendance at the meeting of the American League Against Epilepsy held concurrently with the meeting of the Academy of Neurology.

Dr. Eugene G. Peek, Sr., of Ocala, FMA past president and chairman of the Association's Committee on Legislation and Public Policy, has been appointed by Governor Warren as a member of the Game and Fresh Water Fish Commission, Fifth Congressional District, for a term ending January 4, 1954. Dr. Peek's appointment was approved by the Senate on May 26.

Dr. Russell B. Carson of Ft. Lauderdale was elected secretary-treasurer of the Southeastern Section of the American Urological Association at its annual meeting in Memphis in April.

Dr. Clarence M. Sharp of Jacksonville, director of the Bureau of Tuberculosis Control for the Florida State Board of Health, attended the meeting of the National Tuberculosis Association in Cincinnati, May 14-18, where he presented a paper before the state sanatorium and tuberculosis control directors.

Dr. Samuel M. Day of Jacksonville, secretary-treasurer of the Association, was guest speaker at the May meeting of the local Junior League. He gave a talk on cancer.

Dr. Thos. S. Griggs of Miami Shores has left his practice for a two year course in anesthesiology at Charity Hospital in New Orleans.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR SALE: A practically new McKesson B.M.R. machine. Write Dr. Banks H. Goodale, 1940 Silver Street, Jacksonville, Fla.

FOR SALE: At sacrifice, One Dr. C. J. Imperatori Treatment and Diagnostic Unit (Compressor, etc.), and One Castle Auto-Clave Sterilizing Unit. Excellent condition. Write A. A. Quarterman, 233 West Duval Street, Jacksonville, Phone 4-8293.

FOR SALE: General Electric Model B Electrocardiograph, battery operated, $200.00. Cardiotron, Direct Writer Electrocardiograph, 3 years old, $375.00. Write Keleket X-Ray of Florida, 511 N. E. 15th Street, Miami, Fla.

COMPONENT SOCIETY NOTES

Dade

Guest speaker at the June 5 meeting of the Dade County Medical Association was Dr. Lawrence Shinabery, president of the Association of American Physicians and Surgeons, who spoke to the group on phases of socialized medicine and taxation.

Duval

The Duval County Medical Society held its regular monthly meeting June 5 in the Sellers Auditorium. On the scientific program was a motion picture dealing with the functions of the kidney in health and disease. There was a panel discussion on "Larva Migrans" by Drs. Jack H. Bowen, Francis A. Copp, Lauren M. Sompayrac and J. Frank Wilson, and James E. Scatterday, D.V.M., of the United States Public Health Service.

Marion

"Carcinoma of the Lung" was the subject of a scientific paper read by Dr. Leffie M. Carlton, Jr., of Tampa at the regular monthly meeting of the Marion County Medical Society on May 15 in Ocala. Dr. John N. Moore of the local society led the discussion on Dr. Carlton's paper.

Hillsborough

The Hillsborough County Medical Association met in the Floridan Hotel in Tampa on June 5. The scientific program was headed by Dr. Sherman B. Forbes with an address on "New Surgical Approach to Buphthalmos."

Pasco-Hernando-Citrus

All members of the Pasco-Hernando-Citrus County Medical Society have paid their state dues for 1951.

Pinellas

Members of the Pinellas County Medical Society and the Hillsborough County Medical Association were recent guests of the medical staff of the Bay Pines Veterans Hospital. Dr. William F. Hamilton, Jr., professor of physiology at the University of Georgia School of Medicine, read a paper on "Practical Applications of our Present Knowledge of the Pulmonary Circulation."

Volusia

At the regular monthly meeting of the Volusia County Medical Society James T. Griffiths, Jr., Ph.D., University of Florida entomologist, spoke on the dangers of parathion poisoning.

Washington-Holmes

All members of the Washington-Holmes County Medical Society have paid 1951 state dues.

OBITUARIES

Manuel A. Perez

Dr. Manuel A. Perez of Tampa died at St. Joseph's Hospital in that city on April 7, 1951, after a prolonged illness. He was 41 years of age. Interment took place at Myrtle Hill Cemetery on April 9.

The son of Emilio and Aurelia Perez, Dr. Perez was born in Tampa on Oct. 19, 1909. He attended Holy Names and Jesuit High School. He received his premedical education at Loyola University in New Orleans and his medical degree from Loyola University Medical School in Chicaga in 1934. After interning at St. Vincent's Hospital in Jacksonville, he began the practice of medicine as a pediatrician in Tampa. Dr. Perez was on the active staff of St. Joseph's Hospital and the Tampa Municipal Hospital, where he was Head of the Pediatrics Service. He was a member of Elks Lodge No. 708 and a member of Christ the King Catholic Church.

Dr. Perez was a member of the Hillsborough County Medical Association, the Florida Medical Association, the American Medical Association and the Southern Medical Association. He also held membership in the Florida State Pediatric Association and the American Heart Association. At the time of his death, he was Chairman of the Committee on Child Health of the Florida Medical Association.

In 1936 Dr. Perez married the former Miss Lillian E. Graham of DeLand, who survives him. Also surviving are a son, Manuel Robert; three daughters, Eleanor Gloria, Sylvia Jean and Patricia Ann; and a sister, Miss Mary Perez, all of Tampa.

Robert Baltzell Glenn

Dr. Robert Baltzell Glenn of Jacksonville met death on April 25, 1951 in an airplane collision off Key West. He was 34 years of age.

Born in Ennis, Texas, on Feb. 19, 1917, Dr. Glenn was the son of John R. and Grace Glenn, now residing in Opdyke, Ill. He was reared and received his early education in Waycross, Ga. In 1938 he was awarded the degree of Bachelor of Science from the University of Georgia and in 1941 the degree of Doctor of Medicine from the Schooi of Medicine of that institution. He then served an internship at the Duval Medical Center in Jacksonville before entering the United States Army from a reserve status in July 1942. For approximately two years he served in the Pacific theater. He was discharged from active duty with the rank of major in July 1946.

For two years following his military service Dr. Glenn was a resident surgeon at the Duval Medical Center in Jacksonville and in July 1948 entered private practice in that city. He was on the associate staff of the Duval Medical Center and on the visiting staff of the local hospitals. He was an active member and a junior deacon of the Riverside Baptist Church. He held membership in the Seminole Club and the San Jose Country Club. His fraternity was Sigma Chi.

Dr. Glenn was a member of the Duval County Medical Society, the Florida Medical Association and the American Medical Association.

(*Continued on page 59*)



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Because intestinal amebiasis may be complicated by extra-intestinal involvement, it is recommended that Aralen (chloroquine) diphosphate be employed in addition to Milibis for the treatment of all cases of amebic infection.

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*Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.

In August 1942 Dr. Glenn was married to Miss Catherine O'Neal of Blackshear, Ga., who died with her husband. Surviving are a daughter, Marjorie Jean, and a son, Robert B., Jr., of Jacksonville; the parents, Mr. and Mrs. John R. Glenn of Opdyke; a brother, John R. Glenn, Jr., of Detroit, Mich.; and a sister, Mrs. G. R. Newman of Rupert, Ida.

James Ernest Wallace

Dr. James Ernest Wallace of Jacksonville was killed in an airplane crash off Key West on April 25, 1951. He was 37 years of age.

A native of Oklahoma, Dr. Wallace was born in Sapulpa in 1914. He received the degree of Bachelor of Arts from Mercer University in 1939 and the degree of Doctor of Medicine from Temple University School of Medicine in 1943. Following an internship at the Allegheny General Hospital, Pittsburgh, Pa., he served as resident in pathology at the William H. Singer Memorial Laboratory of that hospital. He was licensed to practice medicine both in Pennsylvania and Florida.

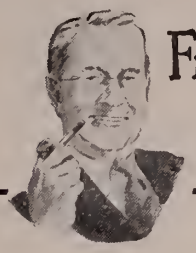
During World War II, Dr. Wallace spent most of his twenty-seven months' service in the Army overseas. He became Chief of Laboratories of the 313th General Hospital in Manila, P. I., and later Director of the 19th General Laboratories. He was discharged from military service on Dec. 23, 1946. In February 1947 he became Assistant Pathologist for Hamot Hospital, Erie, Pa.

In March 1950 Dr. Wallace came to Jacksonville as Pathologist for St. Luke's Hospital and a few months later was appointed Chief of the Department of Pathology. During his one year at St. Luke's he was most successful in reorganizing the laboratory facilities and in establishing an excellent technician's school. He was elected to the vice presidency of the staff of that institution, beginning July 1, 1951. He was also an Assistant in Pathology at the Duval Medical Center.

Dr. Wallace was a member of the Duval County Medical Society and the Florida Medical Association, a fellow of the American Medical Association and the American Society of Clinical Pathology, and a diplomate of the American Board of Pathology. He was also registered with the College of American Pathology.

Dr. Wallace's wife, Charlotte, met death with him in the tragic airplane collision. They are survived by their two small children, Judy and Eileen.

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From where I sit *by* Joe Marsh

"One For The Book"

Miss Reynolds, our town librarian, really put a smart-aleck motorist in his place last week—happened right in center of town, at the corner of Main and Walnut.

Her car stalled, tying up traffic. Most drivers just waited quietly—realizing she couldn't help it—but one fellow kept blaring away on his horn.

So Miss Reynolds gets out of her car, walks over and says sweetly, "I'm afraid I can't start my engine. But if you'd like to try I'll stay here and lean on that horn for you." That stopped him—cold!

From where I sit, a lot of us are sometimes overeager to "sound off" before we really understand what it's all about. Like those who would tell a man where and how he should practice his profession . . . like others who would deny their neighbors the right to a glass of beer now and then. It's a good idea to get a true picture of the situation before blasting out at anyone who "gets in the way" of our own pet ideas!

Joe Marsh

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We Can Dream

Perspective is one of the biggest obstacle hazards in any organization and the most difficult to synchronize because everyone has it in varying degrees. Like common sense each person thinks himself so abundantly provided with it, that even those who are most difficult to please in everything else do not usually desire a greater measure of this quality than they already possess.

Yet, in an organization such as the Woman's Auxiliary to the Florida Medical Association, a developed perspective directed at a common objective is a prerequisite to progress.

It does little good for your president to have an itinerary which is planned to further us along our way if the nineteen "county-parts" of the vehicle used for travel operate in various degrees of efficiency due to being out of touch.

Unless each county knows WHY we are and WHAT we are doing, HOW we operate and WHERE we are heading, the energy and enthusiasm of the person at the wheel is of little value. We may start off in high gear, but unless we are connected we'll only spin our wheels.

Each year at the annual meeting we have an executive turnover. A new group picks up where the other leaves off and hopes to end the year with something to contribute to the next group. It is a relay system wherein each depends upon the other to carry on.

This is time for inventory. The president of each county auxiliary has an obligation to send in a complete list of the county working parts so that we can know with what we have to work. They

must identify themselves so that we can reach them with the information they need in order to correlate our activities.

So the perspective we must work to develop is one of personal responsibility of each elected member to "contact." The cooperation of county members is the heart-beat of the state and this organ can only function with vitality if the arteries which feed it are in good active condition.

Imagine the satisfaction all could enjoy if each county auxiliary sent in a complete list of its working group to the state president, so that the material sent to each state by the national auxiliary could be funnelled to the local level and acted upon by respective chairmen without delay.

Coordination must precede action in order to achieve. This may sound difficult, but we can dream, can't we?

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FRIEND OF THE PEOPLE, THE LIFE OF DR. PETER FAYSSOUX OF CHARLESTON, SOUTH CAROLINA. By Chalmers G. Davidson. Pp. 151. Price, $2.75. Columbia, S. C., The Medical Association of South Carolina, 1950.

The Medical Association of South Carolina presents this delightful biography of its first president with the assurance that the subject is worthy of the distinction of the first published biography of a native-resident South Carolina physician. The Huguenot Peter Fayssoux, a Revolutionary patriot, an outstanding "practitioner of physic," a leader in local statecraft and a personality of singular appeal made a noteworthy contribution to eighteenth century Charleston. Alexander Garden, Benjamin Rush and many other notables of that day were his friends.

As Surgeon General and Chief Physician of the Southern hospitals during the Revolutionary War, Dr. Fayssoux contributed much to the morale and success of the patriot cause. As a leader of the Anti-Federalists — the "States-righters"— he espoused a lost cause and predicted the future better than he knew. Although achieving conspicuous success as a physician and a rice planter, he never lost the common touch nor his uncommon sympathy for those less fortunate than himself. He remained ever the Friend of the People.

Dr. Chalmers Gaston Davidson, the author, is a native South Carolinian whose literary achievements are well known. He and the Medical Association of South Carolina are to be congratulated on this contribution to the medical history of the South.

NATURAL CHILDBIRTH, A MANUAL FOR EXPECTANT PARENTS. By Frederick W. Goodrich, Jr., M.D. Pp. 176. Price, $2.95. New York, Prentice-Hall, Inc., 1950.

This book is based on the experience of Dr. Frederick W. Goodrich, Jr., at Yale University School of Medicine. It is a happy combination of information on obstetric care and practical psychology for the woman in this period of stress. Information on anatomy, physiology and psychic factors allays her natural fears and prevents feelings of inadequacy from need of sedation and anesthesia. Well described and illustrated exercises encourage the development of little used but important muscles. These assist in proper relaxation necessary for rest, efficient performance during the actual birth and reduction of complications and discomfort afterward. The instructions will provide valuable guidance for the multipara as well as for the woman pregnant for the first time.

As indicated by the chapter headings, the book presents: The Background of Natural Childbirth; Explanation of Natural Childbirth; The Anatomy and Physiology of the Reproductive Organs; Visiting the Doctor; The First Trimester; Relaxation; Exercises; Diet; The Second Trimester; The Third Trimester; Breast-Feeding and Rooming-In; The Physiology of Labor; The Psychology of Labor; The Postpartum Period; Going Home. A bibliography is provided for the patient who wants further references for reading on the subject, and a rather complete index is provided.

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HOSPITAL STAFF AND OFFICE MANUAL. By T. M. Larkowski, M.D., F.A.C.S., and A. R. Rosanova, R.Ph., M.D. Price, $4.95. Pp. 428. Great Neck, N. Y., Romaine Pierson Publishers, Inc., 1951.

This manual is expressly designed to be a reminder, guide and refresher for those already acquainted with the essentials of medical practice. The authors have made every effort to keep the text as short and concise as possible without sacrificing clarity, so that the physician will have readily available in one handy volume essential diagnoses, practical therapeutics, diagnostic aids, laboratory procedures, technics, and even a quick refresher on the most common surgical operations. Omitting the highly theoretical whenever possible, they present the time-tested, the trustworthy, the basic principles of the clinical practice of medicine and surgery in all its branches.

HANDBOOK OF MEDICAL MANAGEMENT. By Milton Chatton, A.B., M.D., Sheldon Margen, A.B., M.D., and Henry D. Brainerd, A.B., M.D. Ed. 2. Pp. 508. Price, $3.00. Palo Alto, Calif., University Medical Publishers.

The Handbook of Medical Management is designed to fill a real need of medical student and practitioner alike and should be of great practical value in the daily conduct of medical practice. Incorporated in this second edition are the new and accepted therapeutic advances of the past year. Most chapters have been revised, and the volume has been increased by some thirty-two pages. There is new material on ACTH and cortisone therapy, endocrine disorders, electrolyte balance, antihistaminic drugs, newer antibiotic drugs, vitamin B_{12}, physical medicine and numerous other topics. Also, drugs mentioned in the text have been brought up to date.



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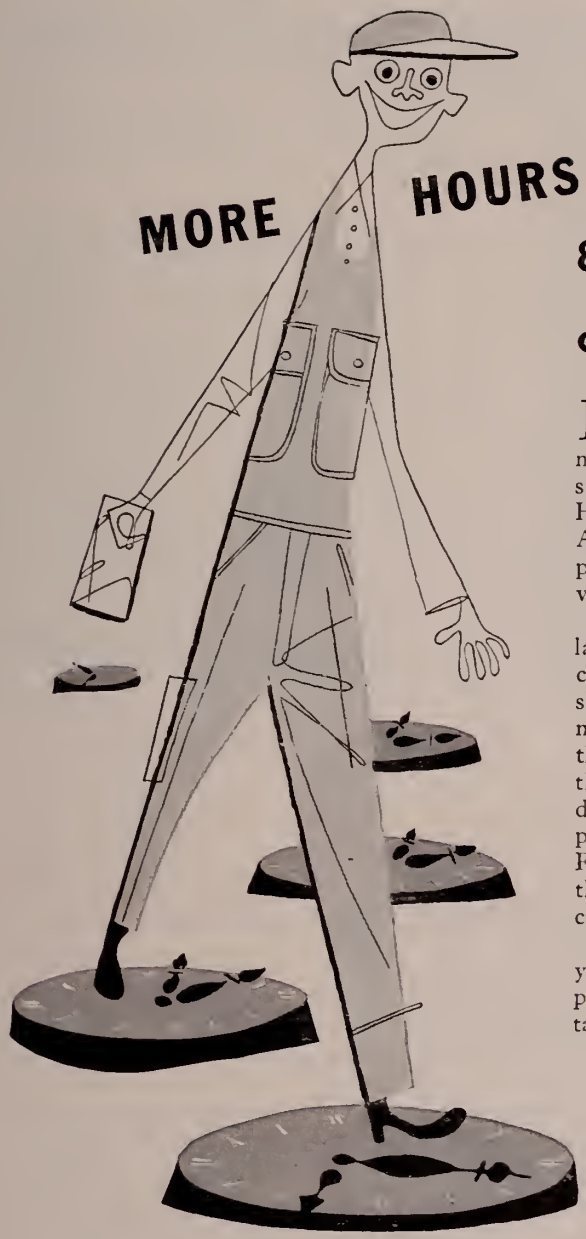
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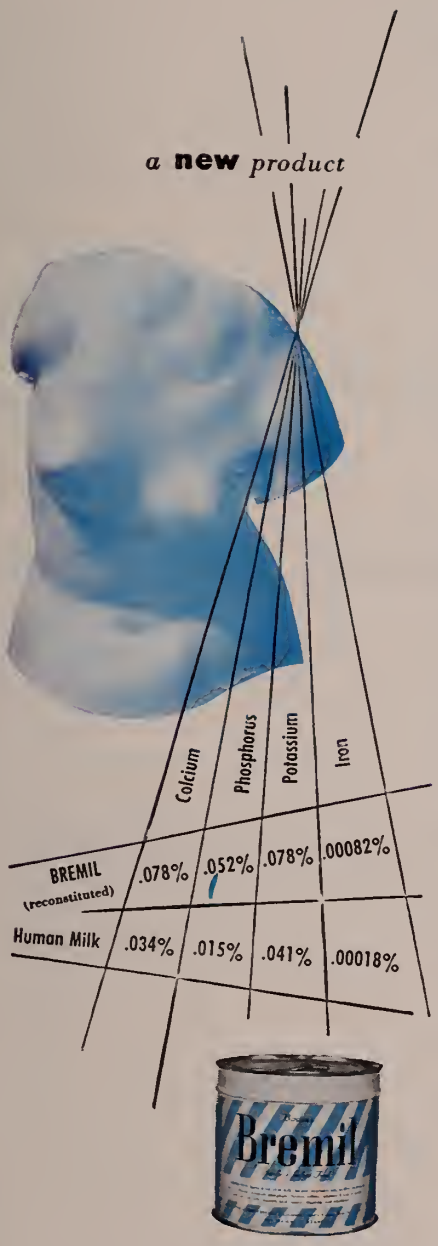
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1. Gardner, L. I.; MacLachlan, E. A.; Pick, W.; Terry, M. L., and Butler, A. M.: *Pediatrics* 5:228, 1950.
2. Nesbit, H. T.: *Texas State J. M.* 38:551, 1943.
3. May, C. D., et al.: *Bull. Univ. Minnesota Hospitals* 21:208, 1950.
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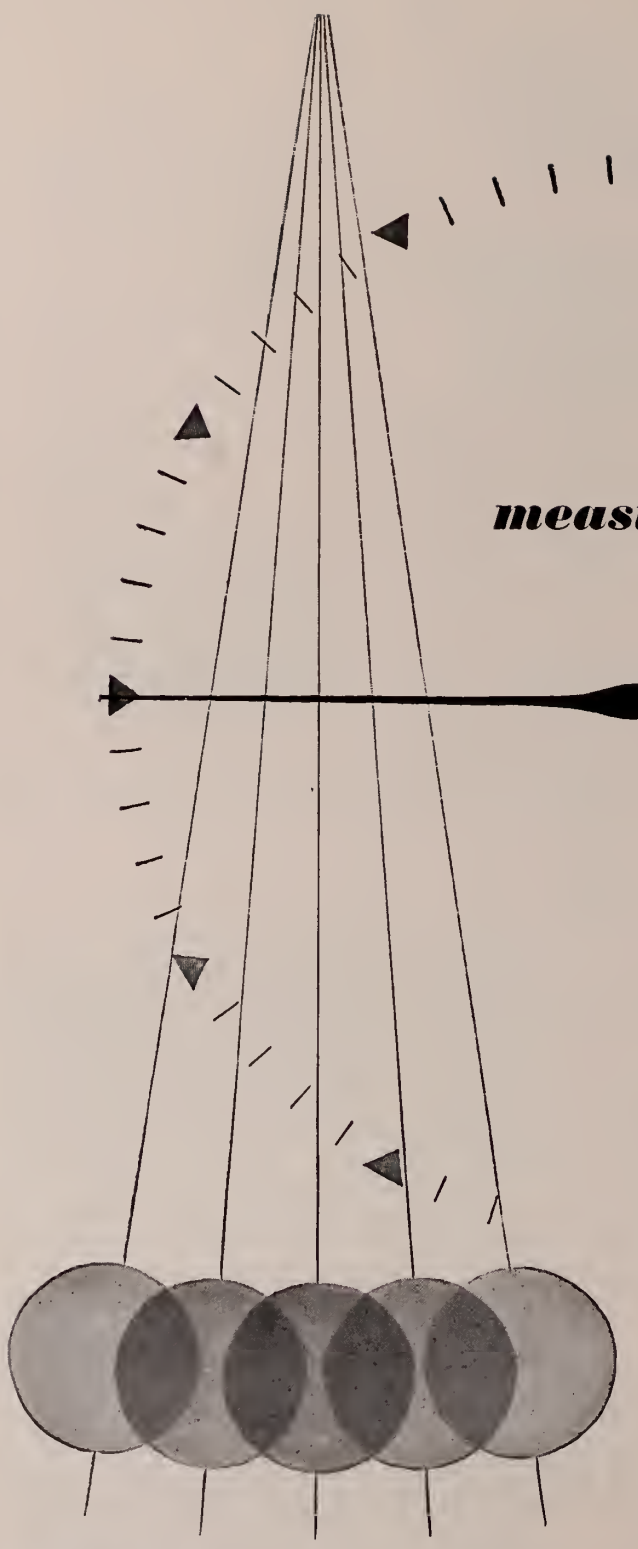
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
da Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '52
da Medical Districts	William C. Roberts, Panama City	Council Chairman	
Northwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Pensacola, 1951
Northeast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Orlando, 1951
Southwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	Bradenton-Sarasota, 1951
Southeast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Vero Beach, 1951
da Specialty Societies			
emy of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	Hollywood, Apr. 27, '52
gy Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	" "
hesiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
ter, Am. Coll. Chest Phys	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
. and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
h Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	" "
trial & Railway Surgeons	Frank D. Gray, Orlando	John H. Mitchell, Jacksonville	" "
ology & Psychiatry	James L. Anderson, Miami	William H. McCullagh, Jacksonville	" "
nd Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
nal & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	" "
pedic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	" "
logical Society	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Laudardale	" "
tric Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	" "
ologic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	" "
logical Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
gical Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
da—			
ic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
od Banks, Association	William C. Thomas, Sr., Gainesville	James M. McClamroch, Gainesville	
ital Society, State	John I. Todd, D.D.S., Jacksonville	Tom Price, D.D.S., Miami	Jacksonville, Apr. 20-23, '52
pital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando, Dec. 3-4, '51
pital Service Corporation	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando, Dec. 2, '51
dical Examining Board	William C. Thomas, Sr., Gainesville	Homer L. Pearson, Jr., Miami	
dical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
dical Service Corporation	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
rses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
rmaceutical Association, State	Mr. Ed J. Pierce, Jacksonville	Mr. R. Q. Richards, Ft. Myers	
blic Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
berculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Port St. Jo	
man's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	Hollywood, Apr. 27-29, '52
ican Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	
I.A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Los Angeles, Dec. 4-7, '51
ern Medical Association	Curtice Rosser, Dallas, Texas	Mr. C. P. Loranz, Birmingham	Dallas, Texas, Nov. 5-8, '51
ma Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19, '52
ia, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 4-6, '52
Hospital Conference	Edwin B. Peel, Atlanta	Mr. R. G. Ramsey, Jr., Memphis	Atlanta, Apr. 16-18, '52
eastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath, B, MacInnis, Columbia, S.C.	Augusta, Ga., Mar. 21-22, '52
eastern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	Boca Raton, Apr. 2-5, '52
eastern Surgical Congress	Joseph S. Stewart, Miami	B. T. Beasley, Atlanta	Atlanta, Mar. 10-13, '52
Coast Clinical Society	Wesley Lake, Pass Christian, Miss.	C. D. Taylor, Pass Christian, Miss.	Gulfport, Miss., October, '51

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	Escambia *Santa Rosa*	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	74	67	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	6	100%	
	Jackson-Calhoun	Jasper B. Dowling, M.D. Route 1 Altha	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	15	
	Walton-Okaloosa	Arthur G. Williams, Jr., M.D. Valparaiso	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker-Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	14	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	John T. Benbow, M.D. Chattahoochee	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	Quarterly 7:30 P.M.	52	49	
	Suwannee	John N. Sims, Sr., M.D. Suwannee St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	7	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		3	100%	
	Taylor *Dixie-Lafayette*	Ralph J. Greene, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	222
B	Alachua *Bradford, Gilchrist, Union*	James M. McClamroch, M.D. 903 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 819 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	47	100%	
	Duval *Clay*	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	244	227	
	Marion *Levy*	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	28	25	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	100%	
	Putnam	Claude M. Knight, M.D. 121 Madison St. Palatka	James W. Brantley, M.D. Grandin	2nd Tuesday 6:00 P.M.	11	100%	
	St. Johns	Joseph A. Shelley, M.D. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	16	14	
	Brevard	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	20	19	
	Lake *Sumter*	H. Durham Young, Jr., M.D. 411 Lakeshore Dr. Leesburg	Lawton F. Douglass, M.D. Umatilla	1st Wednesday 7:30 P.M.	25	23	
	Orange *Osceola*	Fred Mathers, M.D. 314 American Bldg. Orlando	Gerald W. Jones, M.D. American Bldg. Orlando	3rd Wednesday 8:00 P.M.	149	148	B-4-53 Eugene L. Jewett, M.D. Orlando
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	Volusia *Flagler*	Peter A. Drohomer, M.D. 210 Volusia Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	74	71	637
C	Hillshorough	R. Renfro Duke, M.D. 708 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	162	153	
	Manatee	Roderic O. Jones, M.D. 430 10th St., W. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	21	19	
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	Pinellas	Claude B. Wright, M.D. 214 First Fed. Bldg. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	183	181	
	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 203 Van Skike Bldg. Sarasota	2nd Tuesday 8:30 P.M.	42	41	
	DeSoto-Hardee-Highlands-Glades	Hubert W. Coleman, M.D. Box 98 Avon Park	Stanley K. Wallace, M.D. Sebring	2nd Tuesday 8:00 P.M.	26	24	
	Lee-Charlotte-Collier-Hendry	William H. Grace, M.D. 1925 McGregor Blvd. Ft. Myers	Angus D. Grace, M.D. 308 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	24	23	C-6-52 Leldon W. Martin, M.D. Sebring
	Polk	John W. Vaughn, M.D. Box 475 Lakeland	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	86	79	557
D	Indian River	Erasmus B. Hardee, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	
	Palm Beach	R. M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	Lorenzo James, M.D. 1300 N. Dixie Ave. West Palm Beach	3rd Monday 8:00 P.M.	104	96	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	St. Lucie-Okeechobee-Martin	Julian D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	16	14	
	Broward	M. Austin Loveioy, M.D. 409 Blount Bldg. Ft. Lauderdale	Thomas L. Roberts, Jr., M.D. 408 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	80	77	
	Dade	Jack Q. Cleveland, M.D. 167 Alcazar Ave. Coral Gables	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	564	487	D-8-53 Donald W. Smith, M.D. Miami
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MEDICINE

The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVIII AUGUST, 1951 No. 2

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Surgery of Biliary Tract
Lon Grove

Baby Feeding
Walter W. Sackett, Jr.

Massive Hemorrhage
Fred E. Manulis

National Medical Education Foundation
An Editorial

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Volume XXXVIII **AUGUST, 1951** **No. 2**

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

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Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol. 3:95, 1943.

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Hamblen, E. C.: North Carolina M. J. 7:533 (Oct.) 1946.

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.

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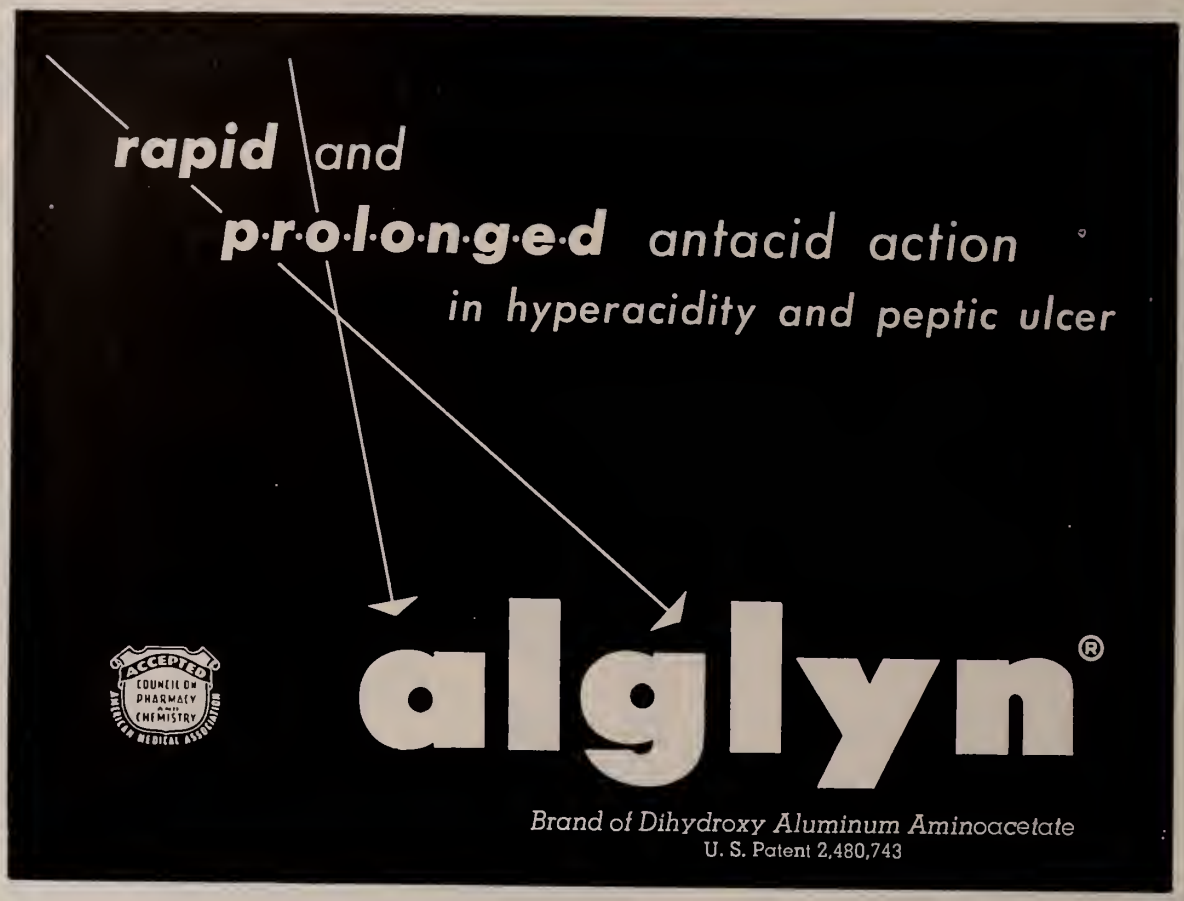
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References:

1. Hammerlund, E. Roy, and Rising, L. Wait, A Comparative Study of the Buffering Capacities of Various Commercially Available Gastric Antacids, J.A.Ph.A., Scientific Edition, 38: 586-588 (1949).
2. Krantz, Kibler and Bell: "The Neutralization of Gastric Acidity with Basic Aluminum Aminoacetate," J. Pharmacol. and Exper. Therap., 82: 247 (1944).
3. Paul, W. D., and Rhomberg, C.: "Medical Management of Uncomplicated Peptic Ulcer," J. Iowa M. Soc., 35: 167-85 (1945).
4. Holbert, J. M., Noble, Nancy, and Grote, I. W., J.A.Ph.A., Scientific Edition, 36: 149 (1947).
5. Holbert, J. M., Noble, Nancy, and Grote, I. W., J.A.Ph.A., Scientific Edition, 37: 292-294 (1948).

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1. Jeans, P. C.: Feeding of Healthy Infants and Children, J.A.M.A. *142*:806 (Mar. 18) 1950.

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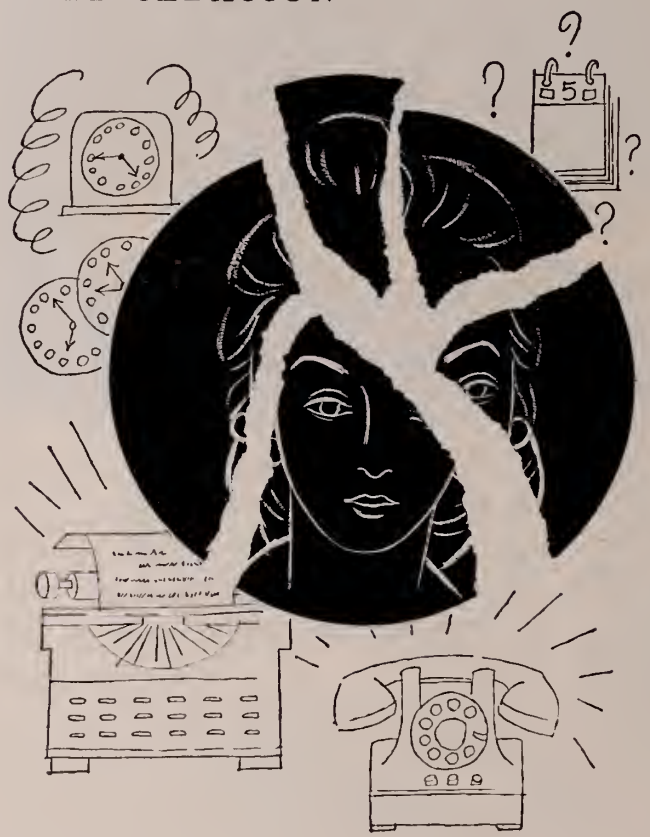
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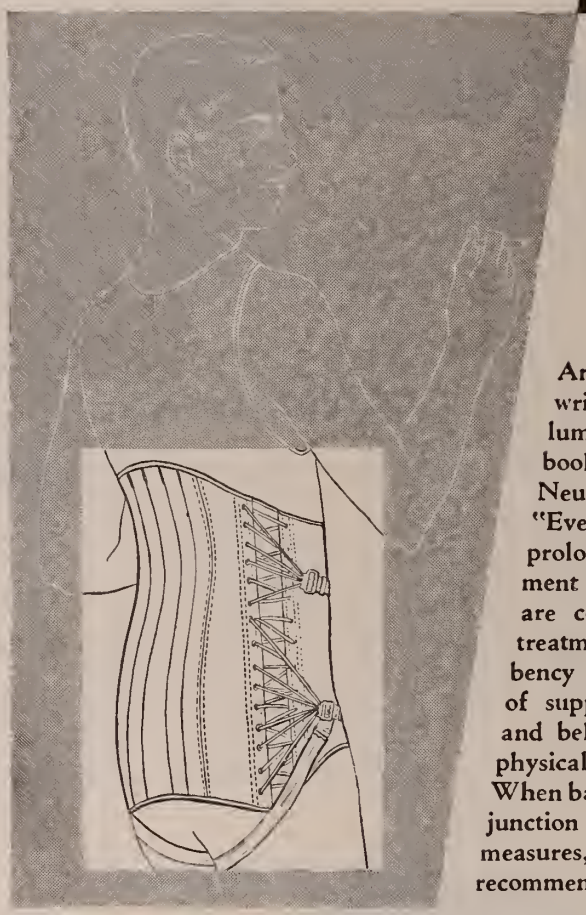
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXVIII Jacksonville, Florida, August, 1951 No. 2

Surgery of the Biliary Tract: A Personal Experience with Eight Hundred and Fifty Consecutive Cases in Private Practice

Lon Grove, M.D.
ATLANTA

This report of surgery of the biliary tract is presented to record the efforts of myself and my associates in this field for the past thirty years, to acquaint our colleagues with the type of procedures employed, and to stimulate suggestions for improvement. Grateful acknowledgment is given to our medical confreres for their aid and cooperation in the diagnosis and treatment of the cases included in this report. By far the larger number of diagnostic studies have been made before the patient has been referred to us. As would be expected, the volume of work has gradually increased, and in 656, or 77 per cent, of the cases the patient has been operated on during the last ten years. Of greater importance and interest is the fact that the mortality has decreased, and during the last ten years has been 0.45 per cent. As will be pointed out in the body of this paper, numerous factors have contributed to this gradual decrease in surgical mortality. Chief among these are more careful evaluation and preparation of the patient; a more effective means of combating infection, especially by the use of antibiotics in recent years; a better understanding and more accurate control of electrolyte and fluid balance; better knowledge and fulfilment of the nutritional requirements of the seriously ill and jaundiced patient; and greater emphasis on the prevention rather than the treatment of postoperative complications.

History of Biliary Surgery[1]

The contemporary operative treatment of surgery of the biliary tract began with the pioneer work of Ephraim McDowell (1771-1830), the first surgeon to open the abdomen for the purpose of removing an ovarian cyst. McDowell's work in ovariotomy laid the foundation for operation on the biliary tract. Prior to McDowell's work, good descriptions of gallbladders were given by Mathew Baillie and Louis Petit in Europe and Samuel Sharp in London. The American pioneer of cholecystostomy was an Indiana man, John S. Bobbs, who in 1867 explored an abdominal tumor which proved to be a distended gallbladder.

Theodor Kocher, of Berne, Switzerland, was the first to perform successfully a two stage operation using the antiseptic technic (1878). William Keen, of Philadelphia, completed an operation also in 1878, unsuccessfully. Marion Sims deliberately operated for gallstones in Paris that same year. From Sims we derived the procedure name of "cholecystostomy." The patient did not survive. Lawson Tait, of Birmingham, England, and Joseph Price, of Philadelphia, were other pioneers who operated deliberately for gallstones in those early days. It will be remembered, only the stones were removed. Cholecystectomy had been done experimentally on dogs, but the first cholecystectomy on a human was executed by Johann August Langenbuch in 1882. Thus, we find biliary surgery is a comparatively recent development in the surgical world.

Incidence of Disease in the Biliary Tract

Blackwell found evidence of gallbladder disease in 16.4 per cent of 6,000 routine autopsies, and it was his opinion that in persons past 30 years of age, more than one half had diseased gallbladders and of this number approximately one fifth had gallstones. Eliason thought that probably 15 per cent have biliary disease. Graham[2] stated that calculous cholecystitis occurs in 20 to

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 24, 1951.
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25 per cent of adults and probably an equal number of persons have cholecystitis without stones. These various figures impress upon us the frequency of disease of the biliary tract, and, as a result, we are impressed with the importance of certain questions, namely, the accuracy in diagnosis, the indications for operation, the effect if the gallbladder is not removed, and whether the present day mortality rate justifies cholecystectomy in the absence of highly active symptoms, particularly gallbladder colic.

This report is based on an experience of 850 consecutive operations on the biliary tract in private patients, and it begins with the second epoch of biliary surgery, cholecystectomy. The argument for cholecystostomy versus cholecystectomy, which occupied such a prominent place in practically all surgical meetings from 1910 to 1915, was beginning to be settled because of the realization that the disease was primarily in the wall of the gallbladder.

Diagnosis

As shown in this report, the cases in which the patient was operated on between 1920 and 1930 revealed too large a percentage of incorrect diagnoses evaluated by present day standards (figs. 1-4). This high percentage occurred because there was no accurate method of diagnosing disease of the gallbladder. It was not until Graham and Cole,[3] in 1924, introduced the cholecystogram, as used today, that we had a really reliable aid in the diagnosis of disease of the gallbladder. This fact is illustrated in our summary of the cases from 1930 to 1950, which shows only 10 per cent of gallbladders removed in this period were without stones, and many of these were cases of acute cholecystitis.

There are no characteristic symptoms that differentiate the types of cholecystitis in the early period of the disease. The chronically inflamed gallbladder, the catarrhal gallbladder, the strawberry gallbladder, and cholesterosis all show practically the same clinical manifestations. Both in the acute and subacute conditions variable symptoms occur, and frequently there is no evidence of fever or leukocytosis, even in the presence of stones. The hydropic gallbladder frequently produces comparatively mild symptoms, while manifestations of an acutely inflamed gallbladder are not infrequently fulminating. It is in the gangrenous gallbladder we encounter the more characteristic clinical manifestations: high tempera-

MORTALITY	1921 1930	1931 1940	1941 1950	Total
NUMBER CASES	41	153	656	850
MORTALITY	3	2	3	8
% MORTALITY	7.3%	1.3%	.45%	.94%

Figure 1.

MORTALITY 1921-1930

1. 7th P.O. day. Chronic cholecystitis with stones, cholecystectomy, acidosis, acute appendicitis.
2. 3rd P.O. day. Acute cholecystitis with stones, cholecystectomy, cardiac.
3. 12th P.O. day. Postoperative stricture common duct, jaundice, exploration common duct.

Figure 2.

MORTALITY 1931-1940

1. 1st P.O. day. Chronic cholecystitis with stones, jaundice, common duct stones, cholecystectomy, exploration common duct, cardiac, shock.
2. 3rd P.O. day. Cholecystectomy 6 mo. previously. Common duct stone, jaundice, exploration common duct, choledochoduodenostomy, lower nephron syndrome.

Figure 3.

MORTALITY 1941-1950

1. 7th P.O. day. Chronic cholecystitis with stones, carcinoma liver, cholecystectomy.
2. 7th P.O. day. Chronic cholecystitis with stones, cholecystectomy, exploration common duct, acute panoreatitis, lower nephron syndrome.
3. 3rd P.O. day. Chronic cholecystitis with stones, cholecystectomy, leukemia, pneumonia.

Figure 4.

ture, high leukocyte count, with definite evidence of peritoneal irritation, and not infrequently a palpable gallbladder.

Tumors of the gallbladder cause no characteristic symptoms by which a diagnosis can be made. Papilloma is the one type of tumor that can at times be demonstrated by roentgen examination. There were 7 cases in this series (fig. 5). A review of the literature raises considerable question as to the relationship between papilloma and malignant disease. Malignant lesions occurred in 13 cases, or 1.8 per cent, in this series (fig. 5). Except in the advanced stages, manifested by metastasis to the liver, the symptoms were not indicative of a malignant condition, and the diagnosis was made only at the time of exploration.

The most convincing evidence of gallbladder disease is the cholecystogram. The cholecystogram is the most important single test in establishing a diagnosis. To quote Dr. Ted F. Leigh, Chief of Radiology at Emory University Hospital:

"The two positive x-ray findings indicative of gallbladder disease are the demonstration of stones and poor concentration, or complete absence of the dye. For accurate interpretation of a gallbladder series, films must be free of fog, and developing solutions must be fresh. In making the films the technician must cone down on the film and should seek to give optimum exposure in compliance with the patient's size, even if it means several repeats on a single film. Too often, because of poor technique, a normal gallbladder is interpreted as pathological, one of the most common causes of error in diagnosis.

"Radiologists feel that a minimum of four to six films is necessary, including some in the upright as well as in the prone position. When colon gas partially obscures the gallbladder in these positions, a lateral decubitus position can be used, with the patient placed on his right side. and the film is made in an anterio-posterior projection. Almost invariably with this technique an unobstructed view of the gallbladder is obtained.

"The degree of gallbladder emptying, following a fatty meal as shown by x-ray films, has come under scrutiny of late, and the prevailing opinion is one of doubt concerning its significance. It has been shown that there is considerable variation in the degree of volumetric contraction following a fatty meal in healthy individuals. We believe that the chief advantage of the post-meal film is not to determine the degree of emptying, but rather to spot any tiny calculi which might be obscured by the larger quantity of the opaque material in the initial films of the series.

"In the 'non-filling' of a gallbladder following oral administration of dye, careful consideration must be given to extra-biliary conditions causing this, such as a pyloric or duodenal obstruction; poor absorption from the small intestine in such states as pancreatic dysfunction; vitamin deficiency; mechanical obstruction; and hepatic disease. A gallbladder series in the presence of jaundice is useless and may be harmful. When all extraneous causes for 'non-filling' are ruled out, there is reasonable certainty the 'non-filling' of the gallbladder is on the basis of disease and not technique.

CHRONIC CHOLECYSTITIS	1921 1930	1931 1940	1941 1950	Total
CHRONIC CHOLECYSTITIS with stones	14	77	478	569
without stones	23	46	58	127
GALLBLADDER-INTESTINAL FISTULA cholecystoduodenal	0	0	3	3
cholecystocolic	0	0	1	1
CARCINOMA OF GALLBLADDER	0	1	12	13
PAPILLOMA OF GALLBLADDER	2	2	3	7

Figure 5.

"Approximately 50 per cent of gallstones contain bile salts and for this reason are opaque to some extent. The more apparent can be spotted on routine abdominal films, but the smaller ones will usually be missed if the films are technically poor or if they are not searched for. These same small stones may be invisible in the opacified gallbladder when their density approaches that of the dye.

"The other 50 per cent of gallstones are pure cholesterol and are non-opaque. These are rendered visible only by filling the gallbladder with opaque dye. When there is faint dye concentration, the shadows of the stones become less well rendered.

"The most difficult roentgenographic interpretation occurs when the calculi are tiny in size—the so-called 'millet seed' calculi. There may be hundreds present, though invisible. Several technical tricks will sometimes overcome this. An over-penetrated film with the patient in prone position may show many concentric negative shadows superimposed on the dye; or a film with

the patient in upright position may show the stones layered in the fundus of the gallbladder or floating between layers of bile. The straight line of translucent dots is characteristic and, even with superimposed colon gas, can be identified. If necessary, further information can be obtained with the lateral decubitus position as described previously."

We do not believe in the removal of the gallbladder shown by roentgen examination to concentrate the dye well but showing delayed emptying without stones. The exception is the case with definite clinical evidence of recurring gallbladder colic. In evaluating cases of this type, we have to accept the fact that in the hands of the best roentgenologists there will be a small percentage of the so-called "millet seed" stones that will not be shown. There were several such cases in this series. The patients in these cases usually go from one doctor to another; they have repeated roentgen studies, and not infrequently are diagnosed as neurotics.

When Should the Chronically Diseased Gallbladder be Removed?

Based on the present day mortality as shown in this report (figs. 1-4), it is our belief that all patients with clinical evidence of gallbladder disease, with gallstones or a nonfunctioning gallbladder should be operated upon before there are complications. Frank Lahey observed, "Our medical friends must overcome the complacency with which they permit patients to go through repeated attacks of gallstone colic." William J. Mayo stated,[4] "A gallbladder containing stones is always infected, and when this organ once becomes restless from the irritation of its host, the chance of a complete reconciliation is improbable." While the reported incidence of malignant disease occurring in chronic cholecystitis varies from 50 to 10 per cent, the possibility of a malignant condition alone justifies cholecystectomy. Cholecystectomy was performed 696 times for chronic cholecystitis in this series (fig 2), and it is interesting to note that there were no deaths in the uncomplicated cases.

In Acute Cholecystitis When Should an Exploratory Operation be Performed?

Since Heuer[5] first advocated early operation for acute cholecystitis in 1937, there has been some division of opinion on this subject, due largely, we believe, to a lack of universal understanding of what is meant by acute cholecystitis, and what is meant by early or immediate operation. Our attitude depends on the patient's condition and when he is seen.

In the patient observed twenty-four to seventy-two hours after the onset of the attack, in whom the pain is persisting or increasing, the temperature is remaining elevated or is mounting, the leukocyte count is increasing, and there is definite evidence of spreading peritoneal irritation, especially pronounced in the right upper quadrant, and the gallbladder is palpable, exploration is undertaken at once, or as soon as the fluid and electrolyte balance can be re-established and the patient's general condition warrants it, as these findings constitute a real emergency.

In the case in which the patient is seen during the first few hours of onset of the illness, especially if there is no history of previous attack, we adopt a more conservative attitude, and operation is deferred to give sufficient time for diagnostic study. If we can eliminate the possibility of the acute abdominal tragedies demanding immediate exploration, such as a perforated ulcer, acute appendicitis occurring in the high or undescended cecum, obstruction with strangulation, or acute mesenteric thrombosis, rarely is it hazardous to take enough time for a careful diagnostic study and proper preoperative preparation before surgery is undertaken. Those advocating immediate surgery point to the high incidence of perforation of the gallbladder in early periods of the disease. We believe this has been overemphasized, as shown in 134 cases of acute cholecystitis in this series (fig. 6). There were 7 perforations with walled-off abscesses, but there was no case of early perforation with a generalized bile peritonitis. Heuer[5] reported a similar experience in a study of 89 cases.

In our experience the diagnosis of acute cholecystitis without previous evidence of gallbladder disease is at times difficult, and if cases of this

ACUTE CHOLECYSTITIS	1921 1930	1931 1940	1941 1950	Total
ACUTE CHOLECYSTITIS with stones	2	22	97	121
without stones	0	6	7	13
CHOLECYSTOSTOMY	2	8	3	13
ACUTE PERFORATING CHOLECYSTITIS	0	3	10	13
ASSOCIATED ACUTE PANCREATITIS	0	0	9	9
ACUTE CHOLECYSTITIS following sigmoid resection	0	0	2	2
following herniorrhaphy	0	0	2	2

Figure 6.

type are not given the advantage of sufficient preoperative study, tragic mistakes will be made. As an example, we were called in an emergency consultation to see a patient visiting in Atlanta from a nearby city, and at the time of examination acute cholecystitis was seriously considered. The patient was advised to enter the hospital for study, to include electrocardiogram, roentgenograms and other examinations, but this advice was not taken. He returned to his home town by ambulance, was taken immediately to the operating room of the local hospital, and died as a result of coronary disease while the exploratory operation was in progress.

After a diagnosis is established, operation should be advised. This has always been our practice. Since the clinical manifestations and course of the disease are frequently not an accurate index to the progress of the pathologic process, we have found it unwise to defer operation for an indefinite period, hoping the acute condition would subside. This is particularly true in the older age group. There were 134 cases in which operation was performed for acute cholecystitis (cholecystectomy in 122 and cholecystostomy in 12), with 1 death, a mortality of 0.74 per cent.

The second episode in biliary surgery began with emphasis on cholecystectomy, which removed not only the stones but the diseased gallbladder. At the present time emphasis is on the third episode, that of common duct surgery. This has been well stressed by Lahey and his co-workers. Emphasis is on the necessity of eliminating not only the disease in the gallbladder, but also in eliminating disease in the common and the hepatic ducts. The incidence of exploration of the common duct when cholecystectomy is performed has gradually increased, until now, in some clinics, as many as 40 per cent of common ducts are routinely explored.

While keenly aware of the necessity for the careful evaluation of stone in the common duct as a cause of residual symptoms following operations for gallbladder disease, we believe there is at this time a tendency by some to overemphasize exploration of the common duct. As shown, we have explored 140, or approximately 20 per cent, of common ducts when performing cholecystectomy (fig. 7), and in 46 per cent stones have been removed. As far as we have been able to determine, only 4 of these patients have returned with symptoms of stones in the common duct. In 2 of them the symptoms developed eight and thirteen years after cholecystectomy, respectively.

The criteria for exploration of the common duct have been a dilated common duct, a thickened common duct with contracted gallbladder, and a history of jaundice. The character of bile aspirated from the common duct has not been a reliable indication of stones. Frequently we have aspirated clear, normal-looking bile, only to open the duct and find stones. On the other hand, the presence of muddy bile is invariably indicative of a stone. The presence of clear bile definitely should not deter one from exploration of the duct. In our experience, small stones alone are not sufficient indication for exploration. Especially is this true if the cystic duct is also small. While, in experienced hands and under satisfactory operating conditions, exploration of the duct can be carried out with little added risk, there is some risk, the convalescence is of necessity longer, and in a large series of cases the morbidity is increased. In the hands of the less experienced, operating under less favorable conditions, there is likelihood of an increased mortality.

The differential diagnosis between extrahepatic obstructive jaundice and parenchymatous jaundice is still a major challenge both to the diagnostician and to the surgeon. While there is no desire to decry the various liver function tests, including biopsy of the liver, because they are indispensable, it is our experience that even when they are performed by experienced technicians, they frequently leave a great deal to be desired. A review of the more recent literature reveals that it emphasizes again the necessity of a carefully taken history as the first prerequisite for a differential diagnosis.

SURGERY OF COMMON DUCT	1921 1930	1931 1940	1941 1950	Total
COMMON DUCTS EXPLORED	1	10	135	146
COMMON DUCT STONES	0	7	63	70 ◆
COMMON DUCT STONES, RESIDUAL	0	1	6	7 *
COMMON DUCT STRICTURE inflammatory and postoperative	1	1	9	11
DUODENOTOMY	0	0	11	11
CARCINOMA, COMMON OR HEPATIC DUCTS	0	0	3	3
CARCINOMA, AMPULLA OF VATER	0	0	2	2

◆ 8 patients had no gallbladder stones
* 2 patients had cholecystectomy elsewhere
* 1 patient required 2 explorations of common duct
* 3 patients required duodenotomy
* 1 patient had removal of common duct stone 13 yrs. following cholecystectomy

Figure 7.

JAUNDICE	1921 1930	1931 1940	1941 1950	Total
OBSTRUCTIVE	1	6	46	53
NONOBSTRUCTIVE	2	5	29	36
Total	3	11	75	89

Figure 8.

In this series there were 89 cases of jaundice (fig. 8). Of this number there were 53 cases of obstructive jaundice; 37 were due to stones, 3 to primary carcinoma of the ducts, 2 to papilloma of the ampulla, and 11 to strictures. Except in rare instances, strictures should not give rise to too much difficulty in diagnosis, because of the well known fact that they invariably follow surgery of the gallbladder, at which time injury to the duct occurred.

The so-called "silent stone" occurred in several cases in this series. It should always be considered in a differential diagnosis, in the patient with unexplained fever, with symptoms and roentgen evidence of gallbladder disease. As an example, a 63 year old woman experienced episodes of recurrent fever which ranged from 101 to 104 F. There was no history of pain, nor evidence, clinical or laboratory, of jaundice, but repeated roentgen studies showed a nonfunctioning gallbladder. An exploratory operation was performed, and a chronically diseased gallbladder with stones was removed. The common duct was thickened and tremendously dilated; it contained one large mulberry stone, which was removed. She wore a T tube for two months without recurrence of the febrile attacks and, until now, six months later, she has been entirely well. This is probably the most convincing example of "silent" common duct stone encountered.

Preoperative Preparation

Emphasis has been on fluid and electrolyte balance and blood replacement when needed. Liver function tests and detailed blood chemistry examinations have been made when indicated. The same has been true of the electrocardiogram. The incidence of associated myocardial disease has been a factor in a fairly large percentage of cases, and this group on the whole has proved a satisfactory operative risk, as shown by the mortality rate.

Technic

Anesthesia used was the inhalation type, usually a combination of gas and ether, and, since its advent, pentothal sodium has been used routinely for induction with great satisfaction. Spinal anesthesia has not been used. At the present time the jaundiced patient receives cyclopropane supplemented with curare given with caution.

Since 1930 the right subcostal incision has been routine, except in rare instances. It is preferred because exposure is direct; wound dehiscence occurs less frequently; there are fewer weak scars; and, since in all cases drainage is employed, an additional incision for drainage is obviated. If exploration shows that additional exposure is necessary, this is accomplished by extending the incision to include a left subcostal incision. It is in the acutely inflamed gallbladder that the subcostal incision has special advantages, because, as stated, the approach is direct; and if caution is taken in opening the peritoneum, and the gallbladder is carefully packed off, it is not necessary to expose the general peritoneal cavity at all. In following this procedure the chances of infection are less, and if later there should be evisceration, it is not of such a serious nature. In 3 cases in which it occurred, we found the omentum and transverse colon adhered to the wound, with no evidence of evisceration of the small bowel, and in all 3 cases the patient recovered.

As is true of most surgeons, we prefer to remove the gallbladder beginning at the ampulla, after the duct and artery have been ligated, but it should be stressed that in certain acutely inflamed gallbladders it will be impossible to identify adequately the duct and artery. In this situation, one should not hesitate to remove the gallbladder beginning at the fundus. At times this is the only safe way in which the duct and artery can be safely identified. The principal objection to removing the gallbladder from the fundus downward is excessive bleeding, and in a poor risk or jaundiced patient this procedure can be hazardous. In this situation one would do well to split the gallbladder down the front, including the ampulla, between clamps, and in this way identify carefully the cystic duct and artery. We have done this in a number of cases without difficulty.

There is still some discussion as to the wisdom of cholecystectomy when one is operating for acute suppurative cholecystitis but, as shown in this report, cholecystostomy is rarely done by

us at this time; only 12 cholecystostomies were included in this series. We believe even gangrenous gallbladders had best be removed, provided the surgeon is operating under conditions favorable to satisfactory gallbladder surgery. The convalescence is shorter, and the morbidity is less. It should be emphasized, however, that there is an occasional acute, gangrenous gallbladder, especially in the patient who is a poor risk, which should be drained, even though the second operation is contemplated at the time. Gray and Lafgren,[6] of the Mayo Clinic, reporting a series of 103 cases of cholecystostomy performed for acute cholecystitis, cited that in 30 of these cases secondary operations for various conditions were required. This number constitutes approximately one third of the original group. In spite of this high incidence of required secondary procedures, these authors stressed the desirability of cholecystostomy in certain cases of gangrene, especially as a life-saving measure in the patient who is a poor risk.

The most common anomaly of the duct and artery has been either a short cystic artery, difficult to expose, or a long, abnormally placed right hepatic artery either crossing the cystic duct anteriorly or closely approximating the cystic or right hepatic duct. It is our practice never to clamp either the cystic duct or the artery. Both duct and artery are isolated by blunt dissection and doubly ligated before they are divided. In order to carry out this procedure, one is forced to visualize clearly these structures, and it will be difficult to injure them. The size of the hepatic artery invariably directs attention to itself. There were no injuries to the duct or artery in this series.

Other anomalies were encountered less frequently. There was 1 patient with congenital absence of the gallbladder, who gave a typical history of recurring pain, interpreted as gallbladder colic. Roentgenograms showed no concentration of dye, and on exploration a tremendously enlarged common duct was demonstrated to contain two large stones. We can safely assume that these stones formed primarily in the duct. There were 2 other patients in whom we thought stones probably had formed in the duct. In these patients there developed symptoms of stones in the common duct eight and thirteen years after cholecystectomy, respectively. They were free of symptoms during the intervening years. There were 2 misplaced gallbladders, one behind the posterior edge of the liver, which had been overlooked at a previous exploration done elsewhere, and one on the left side in a patient with situs transversus totalis.

In exploration of the common duct a T tube is used routinely. We never attempt to explore through the base of the cystic duct; neither do we drain through the cystic duct with a straight tube. The one experience we had with the straight tube resulted in a near tragedy. The tube was believed securely anchored to the cystic duct, but in some way the tip slipped through the ampulla, blocking the ampulla. As a result there was a leakage of bile around the tube through the cystic duct, resulting in a bile peritonitis which involved the entire upper portion of the abdomen, resulting in a large subhepatic and left subdiaphragmatic abscess. Two operations were required for drainage of these abscesses. Fortunately the patient made an ultimate recovery, but only after a stormy convalescence. If a stone is impacted in the lower end of the duct and cannot be removed from above, we prefer to perform a duodenotomy and expose the ampulla to assist in removal of the stone. This was necessary 11 times in this series.

The duct is routinely subjected to roentgen examination for residual stones before the T tube is removed. At the present time this examination is made approximately a week after the operation. In this series residual stones were demonstrated in 6 cases (fig. 7). In 2 cases the primary cholecystectomy was performed elsewhere. In 2 cases the stones were small and were dislodged by irrigating the common duct. Irrigation is recommended in cases of small residual stones before additional surgery is performed. In the cases with larger stones, a secondary operation was performed. When there was no evidence of cholangitis, the T tube was removed early, immediately following roentgen examination of the duct, but when there was a dilated common duct or an impacted stone in the ampulla, the T tube was worn for an indefinite period, in one instance as long as eighteen months, without bad results.

In all but 1 of the cases in which operation was performed for strictures (fig. 7), we anastomosed the end of the duct to the duodenum. In this case an end to end anastomosis was carried out. When sufficient duct was available, the end of the duct was flared by making a short incision in the long axis of the duct. This procedure made possible a larger stoma. The cause of recurrent cholangitis following anastomosis of the duct to the intestine is not well understood; some evidence suggests it is not caused by an ascending infection, but probably by a stricture at the point of

anastomosis. This observation has been emphasized by Walters of the Mayo Clinic. It was with this thought in mind that this technic for enlarging the stoma was used. We reoperated on 1 patient with a strictured stoma, a young woman, 30 years of age, in whom a two stage partial pancreatectomy had been performed for carcinoma of the ampulla. At the first operation, the jejunum was anastomosed to the gallbladder. The patient did well for a time, but after three months she began to have recurrent attacks of jaundice, thought to be caused by recurrent cholangitis due to ascending infection. These attacks occurred with increasing frequency, and finally were associated with pain. It should be stated that at the time the pancreas was removed no residual malignant disease could be demonstrated, and it was thought that all of the growth had been removed with biopsy. Thus, we thought we could reasonably exclude the possibility of recurrence and we decided she should be subjected to an exploratory operation for a possible stricture of the stoma. It was found that gallstones had developed, with one large stone in the common duct, with a stricture of the stoma. The gallbladder was removed, along with the stone from the common duct, and the end of the duct was anastomosed to the jejunum. She had a smooth convalescence, and now, twelve months later, has had no further evidence of cholangitis, has regained her weight, and is back at work. This case suggests that the patient who has persistent symptoms of recurrent cholangitis with no evidence of recurrent malignant disease should have the advantage of an exploratory operation. It is gratifying to note that reports from some clinics show the incidence of stricture of the common duct is decreasing.

In the 2 cases of papilloma of the ampulla (fig 4), the lesion proved to be malignant. In both, operation produced good results. In 1, transduodenal resection of the ampulla was carried out, and in the other radical resection of the pancreas after the Whipple technic. One patient lived for approximately three years and died of an associated disease; the other is now well, approximately three years after radical resection of the pancreas. Our experience prompts us to caution against the diagnosis of papilloma of the duct made by frozen section, as this method proved incorrect in both cases reported. In both, the lesions were reported as benign at the time of frozen sections. As is generally conceded, microscopic diagnosis of malignant papilloma is difficult at best and is at times impossible if made by frozen section.

In the case with progressive and completely painless jaundice of the obstructive type which, at the time of exploration, shows a dilated common duct, but with no palpable evidence of pancreatic disease, one should suspect a primary lesion of the ampulla. These were the findings in both of our cases. In 2 of the 3 cases with primary carcinoma of the ducts (fig. 7), the lesion occurred at the junction of the common and cystic ducts, and nothing was attempted. In 1 it occurred in the lower third of the duct and was treated by anastomosing the duct to the duodenum as a palliative procedure. These lesions were all proved malignant by biopsy.

Postoperative Management

The postoperative management has been fairly routine, with emphasis on fluid and electrolyte balance and blood replacement when needed. Rebreathing and antibiotics are now used routinely for the first two to three days, and early ambulation is encouraged but is not insisted upon, except in rare instances. Treatment is directed primarily against the occurrence of complications rather than the use of antibiotics as a corrective measure. This plan is especially desirable in the older age group, particularly in those with chronic pulmonary and myocardial disease. Some of these patients are fair surgical risks as long as they are not allowed to become seriously ill, but the margin of safety is slight and, if they are allowed to become critically ill, the chance of survival is greatly diminished. For this reason, antibiotics are begun immediately postoperatively, even in the cases in which the operation is for chronic cholecystitis. In the cases of acute cholecystitis smears are frequently taken, but we do not wait for laboratory reports to begin antibiotic therapy. With these precautions there has been a minimum of complications. It will be noted that no deaths occurred in this series when surgery was performed for uncomplicated cholecystitis and, we repeat, surgery should be advised before complications develop. Since the use of the subcostal incision has been almost routine, the postoperative period of hospitalization has been gradually reduced until at the present time it averages approximately eight days.

We have noted that dyskinesia of the duct as an explanation for residual symptoms following surgery of the biliary tract has been overempha-

sized. In our experience, such symptoms are more frequently explained ultimately on the basis of associated pathologic change or some psychosomatic factor. This observation is emphasized in the 1949 report from the Mayo Clinic.[7]

Again, we are reminded of the importance of a careful preoperative diagnostic study.

Summary

This report is based upon a personal experience of 850 cases requiring surgery of the biliary tract in which the patients were operated on in private practice over a thirty year period. Experience urges us to advise operation in the chronic cases before complications develop. Emphasis in the acute cases is placed on careful preoperative diagnosis and proper preparation of patients before surgery. In postoperative management, emphasis is on prevention of complications rather than on corrective measures after complications have developed. This management has resulted in a gradual reduction in mortality (fig. 1) from 7.3 per cent in the first ten year period to 0.45 per cent in the last ten year period.

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Management of Massive Hemorrhage from the Upper Part of the Gastrointestinal Tract

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The occurrence of a massive hemorrhage from the upper part of the gastrointestinal tract creates an emergency which is a challenge both to the security of the patient and to the physician, and remains a potential mortality as long as hemorrhage continues. In no other condition is there a greater need for tempered, experienced, clinical judgment on the part of the physician, as well as for the coordinated facilities of the modern hospital, with adequate nursing, laboratory, and x-ray departments, and most particularly, the services rendered by a well stocked blood bank. In many instances the cooperative efforts of internist, surgeon, endoscopist, roentgenologist and, last but not least, a conscientious house staff, are called into action to conserve life. It is impossible to set up any routines, since clinical pictures vary and are ever changing. Each case presents an individual problem, and constant vigilance is required to achieve desired success.

Etiology

The most common cause of massive hemorrhage of the upper part of the gastrointestinal tract is peptic ulcer. Other causes are ruptured esophageal varices, ulcerating neoplasms, erosive gastritis, diaphragmatic hernia with erosion or ulceration of the herniated mucous membrane, erosion or ulceration of the mucous membrane within a diverticulum, rupture of a sclerotic blood vessel, blood dyscrasias, allergic reactions, aneurysm or abscess ruptured into the gastrointestinal tract.

Symptoms and Signs

The symptoms and signs of massive hemorrhage from this portion of the gastrointestinal tract are due to (A) the hemorrhage itself, and (B) the underlying disease causing the hemorrhage.

A. Hemorrhage.—Massive bleeding may be manifested by hematemesis and melena, or melena alone. A tarry stool or sudden hematemesis may be the mode of onset. Frequently, the sudden desire to defecate, accompanied by weakness and syncope, and the passage of a tarry stool, usher in the attack. As little as 60 cc. of swallowed blood may produce a tarry stool, but a blood loss of at least 350 cc. is required to disturb the mechanism for the maintenance of blood volume. The initial blood loss calls forth certain compensatory mechanisms to maintain blood volume, producing

Read at the Southeast Medical District Meeting, West Palm Beach, Nov. 3, 1950.

peripheral vasoconstriction and an increased pulse rate. The blood pressure remains normal as long as the compensatory mechanism is maintained. As bleeding continues, the body is unable to compensate for the loss in blood volume, and symptoms and signs of shock ensue. These are a lowered blood pressure, rapid thready pulse, pallor, cold and clammy skin, anxiety, restlessness, weakness, dizziness, thirst and dyspnea.

B. Underlying Disease.—Signs and symptoms of the underlying cause of the hemorrhage may also be present, and may be exceedingly helpful in establishing a diagnosis. A previous history of pain compatible with the diagnosis of peptic ulcer may be present. When pain exists as a prodromal symptom, it frequently disappears with the onset of hemorrhage. Evidence of peptic ulcer obtained by previous roentgenologic examination is, of course, helpful in localizing the exact site of the lesion. A past history of chronic alcoholism and dietary deficiency, and the finding of jaundice, ascites, spider angiomas, and hepatic or splenic enlargement should suggest the presence of esophageal varices, due to cirrhosis of the liver and portal hypertension. An abdominal mass and evidence of loss of weight would suggest carcinoma of the stomach. A history of vague distress after meals in the upper part of the abdomen, which is worse on lying down and relieved in the upright position in an elderly obese person, suggests diaphragmatic hernia. Evidence of multiple sources of hemorrhage and splenomegaly should arouse the suspicion of a blood dyscrasia as a possible cause of the gastrointestinal hemorrhage.

Management

Early management of this type of hemorrhage involves consideration of the following basic principles:

A. Procurement of the maximum mental and physical rest for the patient.

B. Restoration of normal blood volume.

C. Institution of measures designed to stop bleeding.

D. Initiation of diagnostic studies to establish the etiology of the bleeding.

E. Recognition of cases of continuous bleeding which will not respond to conservative medical measures, and the institution of emergency surgical procedures to stop the bleeding.

F. Recognition of cases, after hemorrhage has subsided and etiology has been established, in which bleeding is apt to occur again, and institution of elective surgical treatment aimed at the elimination of the possible future hemorrhage.

A. Procurement of Rest.—The procurement of complete mental and physical rest is absolutely essential in the proper management of patients with massive bleeding from the upper part of the gastrointestinal tract. The patient should be placed at absolute bed rest in a hospital, and calmly and confidently assured and reassured that the condition is not serious. A careful selection of competent, intelligent and experienced nursing personnel is most important. The anxiety, restlessness and apprehension, which naturally accompany this condition, must be met with equanimity and a quiet, calm confident approach. No sign of apprehension should ever be displayed by the physician or any others attending the patient.

The judicious use of sedatives is of paramount importance. Knowledge of the patient's particular idiosyncrasies to sedatives is often helpful. In general, one of the soluble derivatives of barbituric acid, such as sodium phenobarbital, which can be given parenterally if necessary, is the sedative of choice. Morphine sulfate should not be used because of its tendency to cause nausea.

B. Restoration of Normal Blood Volume.—Restoration of the blood volume to normal is essential in combating shock due to massive hemorrhage from this area. This is best accomplished by replacing the estimated blood loss by the transfusion of whole blood. If blood is not immediately available, an intravenous infusion of blood plasma is second in preference. If neither whole blood nor blood plasma is available, a 5 per cent solution of glucose in normal saline should be given intravenously and whole blood or plasma substituted as soon as they become available.

In order to evaluate the amount of blood loss and evidence of bleeding activity, certain measurements should be instituted. The pulse rate and blood pressure should be taken and recorded every thirty minutes until one is convinced that the hemorrhage has been controlled. A complete blood count and hematocrit reading should be made on admission to the hospital, and thereafter a red cell count, hemoglobin and hematocrit determination should be made once daily. If the hematocrit reading is normal and the blood volume is obviously reduced, one will be unable to determine the magnitude of the hemorrhage until the dilution factor has become manifest. As soon as the diluting influence takes place, the erythrocyte count and the hemoglobin percentage decrease, thus

serving as a fair index of the amount of blood lost. The extent of the elevation of the blood urea nitrogen may be used as a gauge of the severity of the bleeding, according to some authors. Hyperazotemia may be due to shock with diminished cardiac output and diminished renal blood flow, or to absorption of the products of digestion of blood protein, or to a combination of both factors. Clausen,[1] by introducing 500 cc. of ox bile into the human stomach, doubled the normal blood urea nitrogen concentration in eight hours. Clinically, there is usually noted a maximum rise in blood urea nitrogen twenty-four to forty-eight hours after a massive hemorrhage, with a return to normal at the end of seventy-two hours after active bleeding has ceased.

There is some difference of opinion as to the use of blood transfusion in the treatment of massive hemorrhage from this portion of the gastrointestinal tract. Those who object to the use of transfusion argue that further bleeding may be caused by suddenly elevating the blood pressure. This idea has been largely discredited by the publications of Browne and McHardy[2] and Kirsner and Palmer,[3] who found no evidence of prolonged bleeding nor elevation of blood pressure if the blood is given slowly. It should be emphasized that blood be administered slowly, at the rate of 4 cc. per minute, so that a 500 cc. transfusion requires approximately two hours for complete absorption. Given over a two hour period, 500 cc. of blood does not elevate the blood pressure significantly, unless the patient is in shock. Under these conditions the blood pressure is increased gradually over the two hour period and rarely returns to the prehemorrhage level with one transfusion.

Also to be considered with the maintenance of normal blood volume is the establishment of normal water and electrolyte balance. Since shock is frequently accompanied by oliguria and anuria, it is essential to measure the urinary output daily. In such instances a patient should receive adequate parenteral fluids to maintain a renal output of at least 800 cc. each day. The total daily intake of fluid should approximate 2,000 to 2,500 cc., depending upon the dehydration, azotemia, renal output, presence or absence of edema, and cardiac status of the patient. The water and electrolyte requirements may be regulated by frequent determinations of the blood chlorides, blood urea nitrogen, and carbon dioxide combining power of the plasma.

C. Institution of Measures Designed to Stop Bleeding.—

1. Feeding: The question of whether or not to feed patients with active hemorrhage from the upper part of the gastrointestinal tract has long been a controversial subject. Throughout recent years, more and more authors have favored the principle of early and frequent feeding, which was pioneered in 1927 by Andresen.[4] This was a radical departure from the then popular principle of allowing a preliminary starvation period of twenty-four to seventy-two hours. Andresen's rationale that frequent feedings reduce the amount of unbuffered acid gastric juice and decrease gastric motility has now been well established by animal and human experiments. Andresen's diet consists of four ounces of a gelatin, a lactose-orange juice-water mixture, given every one and a half hours for two days, and then alternated with a cereal gruel, a milk-cream-lactose mixture, from the third to the ninth day.

Since then, many modified diets have been introduced, reaching the other extreme by Meulengracht,[5] who first recommended the immediate use of a high caloric, puree diet, along with alkalis, antispasmodics and iron in the treatment of hemorrhage from ulcer. Included in Meulengracht's list of foods were such items as meat balls, fish balls and broiled lamb chops. The patients were permitted as much food as they desired. Most gastroenterologists today prefer the Andresen diet, or modification thereof, to the Meulengracht regimen, or the principle of early starvation, believing that the former is more likely to promote acid neutralization and gastric motor rest and relaxation than any other program of feeding. It goes without saying that if the patient is in deep shock, or if there is persistent nausea and vomiting, oral feedings must be withheld until the patient is able to retain them.

2. Antacids: If hemorrhage is due to peptic ulcer, the presence of highly acid gastric juice will tend to perpetuate or even extend the confines of the ulcer and may even interfere with the fibrin clot which usually forms at the bleeding point. For this reason the addition of colloidal aluminum hydroxide to the frequent milk-cream feedings will enhance the neutralization of the acid gastric juice. The only untoward effect noted from the use of aluminum hydroxide is constipation. Some authors have introduced aluminum hydroxide in the form of a continuous intragastric drip as the best means of neutralizing acid gastric juice and

preventing fibrin clot digestion, but this procedure has not attained widespread recognition, since intubation may provoke further bleeding and is definitely contraindicated if esophageal varices are suspected.

3. Drugs: Drugs which block parasympathetic impulses, such as atropine and belladonna, have long had a place in the management of hemorrhage from ulcer. More recently methantheline bromide (Banthine), which theoretically performs a medical vagotomy, has been replacing atropine and its derivatives. By its anticholinergic action it reduces hyperacidity and controls hypermotility.

4. Vitamins: Although a deficiency of vitamin C has never been proved to be the cause of peptic ulcer, secondary vitamin deficiency may occur due to inadequacies in diet, and especially during hemorrhage. It is good practice to give 100 mg. of vitamin C daily, parenterally during active bleeding and orally later, until an adequate diet may be taken.

A prothrombin time should be determined on every patient with massive hemorrhage on admission to the hospital. A decided posthemorrhagic prothrombin deficiency may exist in the absence of hepatic disease, although it is more frequently noted with disease of the liver, or of the liver and spleen. The intramuscular injection of 2 mg. of vitamin K every four to eight hours promptly restores the prothrombin time to normal in most cases of posthemorrhagic prothrombin deficiency. If the level does not return to normal, one must suspect severe hepatic damage.

5. Tamponade: Another recent addition to the medical armamentarium in stopping hemorrhage, arising especially from the cardioesophageal regions, is pneumatic tamponade, with or without the addition of topical thrombin. Rowntree, Zimmerman, Todd and Ajac[6] reported modifying a Miller-Abbott tube by occluding the upper six holes and attaching an elongated balloon to the lower three holes. When the balloon was inflated, it produced a satisfactory tamponade along the length of the lower end of the esophagus, with the distal pole of the bag at the cardia. Others have passed the tube into the stomach, inflated the balloon with air, and then pulled it back against the cardia, securing the external portion of the tube against the nostril to prevent slipping.

Since, at necropsy, most ruptured varices are found at, or just cephalad to, the cardioesophageal ring, this procedure will probably successfully tamponade most bleeding varicosities. In those cases in which the hemorrhage is occurring proximal to the area of contact with the bag, the occlusion of the veins supplying the bleeder may well be sufficient to produce hemostasis. After the balloon is in place and distended adequately to secure tamponade, the patient may be given by mouth at thirty minute intervals 5 cc. of a 1:10 buffered solution of topical thrombin for a total of four doses. This solution seeps down around the tamponade and provides additional hemostasis in areas where oozing continues.

D. Diagnostic Studies to Establish Etiology of Hemorrhage.—If active bleeding shows signs of being controlled by conservative medical methods, there is no particular hurry about establishing the etiology. When the indications are present that bleeding has definitely terminated, however, careful roentgenologic studies should be made. In many instances the bleeding source will become obvious. In the absence of definite roentgenologic findings, or when supplemental evidence regarding the nature of the bleeding lesion is desirable, endoscopic examination should be performed. Gastroscopic examination is the only positive way to demonstrate an active gastritis that is responsible for hemorrhage. Esophagoscopy is of use primarily in obtaining biopsy material from a suspected esophageal growth. It should not be used to visualize varices, which are almost always readily shown by proper roentgenologic studies of the lower portion of the esophagus. The introduction recently, by Benedict,[7] of an operating gastroscope, making it possible to obtain specimens for biopsy from suspicious gastric lesions, has added considerably to the value and scope of the gastroscopic study.

Laboratory tests are of much less diagnostic importance than the measures discussed, in determining the source or nature of gastrointestinal bleeding.

The bromsulfalein test may be of inestimable value in helping to screen patients with hepatic cirrhosis from those without disease of the liver. In this way, patients with ruptured esophageal varices may be separated from those bleeding from another site. Zamcheck, Chalmers, White and Davidson,[8] in a study of 61 cases of massive hemorrhage, performed routine bromsulfalein tests, using 5 mg. of dye per kilogram of body weight. They concluded that a continued high retention of the dye occurred in patients with proved cirrhosis of the liver, and a normal retention or one slightly elevated, falling promptly to normal, was

present in patients with no known hepatic disease. Obviously, this test is not infallible, since severe shock, advanced age, and possibly fever causes, but not always, an increase in retention of bromsulfalein dye. It should also be remembered that varices caused by extrahepatic portal obstruction (Banti's syndrome) cannot be distinguished by this test in the absence of hepatic disease. Also to be considered is the fact that bleeding in patients with cirrhosis of the liver can be caused by other lesions than varices.

Gastric analysis should never be made until active bleeding has definitely stopped, and should always be preceded by a roentgen study. The finding of histamine achlorhydria in the presence of a demonstrated gastric lesion is of value because it implies carcinoma as the underlying cause. Otherwise, a gastric analysis is of little value and is a needless procedure. It should never be done if esophageal varices are at all suspected.

When bleeding is due to a blood dyscrasia, such as thrombocytopenia, proper blood studies are obviously diagnostic.

In the presence of continuous bleeding, which will necessitate emergency surgery, roentgen examination should be made in an attempt to locate the lesion. A patient should not be examined while in clinical shock, but, as soon as the blood volume can be replaced with adequate transfusions, the roentgen examination should be performed, in the presence of continued bleeding. The examination should be performed without any palpation, with the patient in the horizontal position; peristalsis and gravity should be utilized, by turning the patient from side to side, as a means of distributing the barium over the inner surfaces of the esophagus, stomach and duodenum. Blood clots that lie in the stomach handicap the proper interpretation of the roentgenograms, although they do not prevent the diagnosis of varices of the esophagus, diaphragmatic herniation, large ulcers of the stomach, or ulcers of the duodenum.

Examination of the bleeding patient should not be stopped at the duodenal cap. Tumors of the duodenum are rarer than those of the stomach, but they do occur, and unless carefully looked for, are frequently missed. Demonstration of a possible source of bleeding should not prevent one from continuing the examination to its completion, unless the patient is in a precarious condition, since occasionally another bleeding lesion may be found. Any patient in whom early examination has not demonstrated the cause of the hemorrhage should be re-examined at a later date, if the hemorrhage has subsided, when palpation is possible and the patient is permitted to stand. Some bleeding lesions are demonstrated during the early examination, and others at a later, more convenient and more thorough one. In spite of every diagnostic maneuver known to the roentgenologist, the source of bleeding in a certain number of cases will remain obscure.

E. Emergency Surgery.—In any given series of cases with massive hemorrhage from the upper part of the gastrointestinal tract, the bleeding, under medical management, will cease spontaneously in the majority of instances, and in a minority will prove fatal if emergency surgical intervention is not instituted. The selection of those patients whose hemorrhage will continue unabated without surgery and prove fatal from those whose hemorrhage will be controlled by conservative medical management alone is often extremely difficult. Each patient must be carefully individualized, and observed closely, while under conservative medical management for twenty-four to forty-eight hours. To operate routinely in all cases of severe bleeding would result in a mortality far greater than with medical treatment alone.

Since peptic ulcer is by far the most common cause of massive bleeding, a more detailed discussion of its surgical management is in order. In patients with fatal hemorrhages, the location of the ulcer, if duodenal, is on the posterior duodenal wall and, if gastric, on the lesser curvature of the stomach. The blood vessels causing the fatal hemorrhage are the pancreaticoduodenal and the right and left gastric arteries, or their major branches. Local ligation of the vessels giving rise to hemorrhage has not consistently and permanently controlled hemorrhage. Local excision of the bleeding ulcer and gastric resection, including removal of the ulcer, have given the best results.

Massive, continuous, persistent hemorrhage from peptic ulcer, in spite of a strict medical program and adequate blood transfusions, is an indication for surgical intervention. The recurrence of severe hemorrhage with evidence of shock, several days after recovery from a massive hemorrhage, is another indication for emergency surgery. The age of the patient is an important factor. Fatal hemorrhages are likelier in patients over 50 years of age because of a higher incidence of arteriosclerosis and cardiorenal complications.

Fatal hemorrhages are less frequent among women than among men, and the statistical chance of recovery with medical management in either sex is better after multiple hemorrhages than with the initial hemorrhage. The question of when to operate in the case of continuous massive bleeding has been discussed by many authors. Finsterer,[9] Gordon-Taylor[10] and Heuer,[11] advocated early operation, within twenty-four to forty-eight hours, to save the most lives, since the mortality rate rises precipitously after this period.

F. ELECTIVE SURGERY.—After the initial hemorrhage has subsided and diagnostic studies have been initiated to establish the underlying condition responsible for the hemorrhage, the finding of certain specific lesions may be an indication for elective surgery. The presence of a neoplasm of the esophagus, stomach, or upper part of the small intestine would be an indication for surgery. The finding of a gastric ulcer, in some clinics, would be an indication for routine subtotal gastric resection, and in others, would be an indication for resection if the ulcer failed to heal after an adequate trial on strict medical management. Bleeding from ruptured esophageal varices due to portal hypertension from cirrhosis of the liver might be an indication for one of the new shunting operations between the portal and systemic venous systems recently pioneered by Blakemore[12] and other vascular surgeons.

Patients who recover from massive hemorrhage due to peptic ulcer present an important problem. The majority of those patients who have had two or more hemorrhages are likely to suffer from further episodes of bleeding. Thus, if the patient, particularly in the older age group, has had two or more massive hemorrhages from peptic ulcer, elective surgery should be contemplated, provided there are no definite contraindications such as cardiovascular or renal complications. The operation of choice in cases of this type is subtotal gastrectomy.

Summary

The proper management of patients with massive hemorrhage from the upper part of the gastrointestinal tract requires the cooperative efforts of internist, surgeon, endoscopist and roentgenologist, in a hospital with conscientious house staff, adequate nursing care, and a well stocked blood bank.

Individualization of each patient is essential.

Adequate blood replacement and maintenance of normal blood volume and electrolyte balance are of paramount importance.

Etiology should be established shortly after bleeding stops in those cases in which bleeding subsides spontaneously, and as early as possible in those cases in which the lesion appears to bleed continuously.

In about 85 per cent of all cases there is response to conservative medical management, and the hemorrhage subsides spontaneously. After the etiology has been established, in a small percentage of these cases there will be indications for elective surgery to prevent further bleeding.

In the remaining 15 per cent the continuous bleeding requires surgical intervention. In these cases, as much diagnostic information as is practical and possible should be obtained early, and surgery should be instituted within twenty-four to forty-eight hours after the onset, since the mortality rate rises precipitously after this period.

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A New Concept of Baby Feeding

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There is presented herein a new concept of baby feeding based on a six hour feeding interval from birth. This regimen at any selected date easily evolves into a three meal a day schedule. This is in contrast to the generally accepted standard of a four hour interval and to the more recent ideas of a demand schedule. This concept further involves the earlier introduction of foods other than milk.

In routine office practice one is astounded by the number of hungry babies, the colicky babies, the multiplicity of feeding problems and the many insecure mothers who besiege the general practitioner. For a long time I have ruminated upon the part which present popular feeding theories play in these problems and, through a series of events to be related shortly, I offer my experiences and results with a six hour feeding schedule as introduced at birth, as an answer to these problems.

Probably no field of medicine has been subjected to so much unscientific speculation as has the art of baby feeding. Despite the fact that medicine today is more apt to advise the adult that he is eating too much and too often, the trend in the feeding of infants is to feed them just as often as they manifest hunger, and this manifestation usually is agreed upon as being merely the act of crying. Contrary to general trends, it is my opinion that normal infants do much better on scheduled, further spaced feedings and, what is more, the parents also thrive on this schedule.

Until 1940, it was the common practice to teach, in pediatrics, that babies should have nothing more than milk and orange juice until the age of five months. In the early nineteen-forties there emanated from pediatric centers in Boston and New Orleans the thought that infants could be put on a three meal schedule at three to four months of age. This naturally involved the introduction of foods other than milk at a much earlier period than three to four months, so that my attempts to test this theory led to starting babies on foods other than milk as early as four to six weeks. In 1948 a newborn infant was encountered with a complete duodenal obstruction. This infant survived such nourishment as was limited to parenteral administration for a period of three weeks, during which time diagnostic data were being collected. He subsequently tolerated a gastrojejunostomy as few adults could. The rapid and striking manner in which this newborn infant reached normalcy, as was determined by standards set up by his twin, made one stop and cogitate as to the actual importance of feedings in the neonatal period. It was these events, plus the casual remark of a nurse in regard to the routine 2 a.m. feeding, which convinced me that babies might do just as well on infrequent feedings as on frequent feedings. This remark was, "Why start them on something you plan to stop so soon?"

A review of the literature reveals a paucity of data, particularly scientific, as to the frequency of infant feedings. The early Egyptians believed that breast milk should be the sole source of nourishment in the neonatal period with nursing to be continued into the third year of life. Hippocrates did not mention the frequency of infant feeding in his writings. Soranus, who antedated Aretaeus and Galen, thought that for the first two days the newborn infant should not be nursed at all. Aëtius, who followed Aristotle, was the only advocate of a three meal schedule in the long history of medicine. He advised nursing infants only three times daily for six months, this diet to be varied with eggs, honey and wine, with weaning to take place at twenty months.

Dewees, one of the early American professors of midwifery, made little mention of the frequency or regularity of feeding, but pointed to the danger of feeding in quantities too great. More recently Grulee, in speaking of "neurotic infants," cautioned against irregular and too frequent nursing, whether this produces colic or not. He mentioned two schools of thought as to the interval of feeding, namely, one school leaning to the two hour interval and the other to the four hour interval. Hill wrote of feeding babies four to five months of age who will not take large amounts at one time

Read before the Florida Academy of General Practice, First Scientific Meeting, Orlando, Oct. 22, 1950.

and advocated feeding them to advantage on a two and one-half hour schedule. Further, he approved of feeding the baby all he will take irrespective of calories. For habitual loss of appetite he mentioned a number of causes, among them "too frequent feedings, I mean intervals of less than three hours." In writing of children 1 to 4 years old, he stated that "a child frequently does not like solid food and as each new article of food is begun he spits it up."

With these meager and still conflicting theories on feeding of infants in mind, I proceeded with my mental gyrations as to the frequency of infant feeding with the idea of trying out my theories on certain selected cases. One of my patients apparently fell in step with my musings and requested that her baby (the fourth) be permitted to try this new schedule; and so when this baby A was born, he was put on a three meal a day schedule from birth; at the time of leaving the hospital at the age of 8 days, he was taking 6 ounces at each feeding. Baby B with a birth weight of 5½ pounds was put on a similar schedule. This baby, who was subjected to unusual circumstances not of a physical nature, was observed in the hospital for several months and will be the subject of discussion in a later paragraph. Baby C had as his parents apartment dwellers and was the initiating factor in the introduction of a fourth feeding at midnight. These babies do as all babies will, awake and cry during the night, and for the benefit of neighbors and parents this midnight feeding was instituted.

With a total of approximately 32 private babies and 18 institutional babies on this regimen, these constituting a source of trial and error, the following schedule has evolved:

At birth—Breast and/or bottle is given at 6 a.m.; 12 noon; 6 p.m.; and 12 midnight.

At three to four days—Cereal is added to the 6 a.m. and 6 p.m. feedings.

At ten days—Strained vegetables are added at noon. Peas, beans and carrots are suggested for starting.

At seventeen days—Strained fruits are added at the 6 p.m. feeding. Cereal is dropped or gradually decreased in quantity at this feeding.

At weekly intervals—Add strained meats, orange juice (usually diluted), custards, soups, mashed ripe banana and hard boiled egg yolk.

Some form of cod liver oil may be worked in at any convenient period. The midnight feeding is dropped at any time convenient to the mother, the earlier the better. Many mothers are doing this of their own accord, thus placing their babies on a three meal a day regimen often as early as three weeks.

Studies of the individual babies subjected to this regimen, made with the limited facilities available to the average general practitioner, reveal an astounding approach to the average baby. Charts too cumbersome for publication reveal a surprising paralleling of the weight curves of the observed infants to those of the average infant.

Table 1 illustrates weights recorded on routine visits. Inasmuch as all babies did not come in at the specified times, about one third of the weights were arrived at by reading them from graphs kept on all babies. There are 6 babies whose records are not included in this chart because these babies did not adhere to the six hour schedule, though I know of no instance in which the early introduction of foods was not followed closely. There are also another 5 babies who have not been on the schedule long enough to give weight readings for the first month.

There is not represented here a group of approximately 18 institutional babies concerning whom only generalized conclusions can be drawn at this time. The nursing staff is well satisfied with weight gains exhibited so far. Because these infants are of a mixed age group, and come and go at the direction of welfare authorities, it will be some time before accurate conclusions can be drawn from this group. It might be noted here that in no instance did these infants experience the slightest difficulty in conforming to the six hour interval between feedings.

Unfortunately, because of the short hospital stay of the modern obstetric patient, there are no figures to illustrate faithfully the reluctance of these babies to meet the daily weight gain usually observed in the first weeks of life. In my opinion, this discrepancy can be offset by slight alterations in feeding during these early days of life; some of these alterations have already been introduced and are represented in the schedule set forth here.

A limited number of laboratory studies show little or no variations from the norm. For instance, on Baby B on the eighteenth day of life laboratory reports were as follows: red blood cell count, 5,250,000; hemoglobin estimation, 106 per cent (17 Gm. Sahli); color index 1.0; white blood cell count, 16,200; differential count, eosinophils 1, stab forms 4, segmented forms 21, lymphocytes 82 and monocytes 2. There was moderate macrocytosis with anisocytosis. Urinalysis showed: col-

Table 1. — Weights of Babies at Various Age Levels

	At Birth		1 month		3 months		5 months		9 months		12 months		14 months		24 months	
Normal	7 lb.	4 oz.	8 lb.	12 oz.	11 lb.	12 oz.	14 lb.	8 oz	18 lb.	12 oz.	22 lb.	0 oz.	23 lb.	0 oz.	28 lb.	0 oz.
Baby A	9	10½	10	0	14	2	18	4	19	12	21	8	24	0		
B*	5	6	6	2	10	0	12	0	15	0	17	3				
C	8	4	9	9	13	0	16	3	21	7	23	0				
D	7	10	8	12	10	0	13	2								
E	7	8	8	12	13	8			(Unable to contact)							
F	8	1	9	3	11	12	16	9								
G	7	3½	8	10	12	10	16	6								
H	7	11	9	2½	12	5	15	9								
I	7	1	8	6					(Left town)							
J	6	2½	7	10	12	12	16	3								
K	8	5	9	7					(Unable to contact)							
L	7	5	9	2					(Left town)							
M	7	9	8	7	12	0										
N	6	8	7	5	9	7½			(Anemia problem)							
O	5	7	6	2	10	6										
P	10	5	11	10	15	4										
Q	7	1	8	10	13	3										
R	6	0	7	0	8	12										
S	8	8	9	6												
T	6	9	8	0	14	0										
U	8	1	8	11	11	3										
V	5	6	7	2												
W	7	10	9	0												
X	8	4	8	12												
Y	6	1	8	0												
Z	6	9	7	10												
AA	7	7½	8	5												
BB	5	7	6	4												

*This infant was the only one in whom weight gains could be observed daily during the first two months of life. The maximum weight loss in the neontatal period was 2 ounces. It was eleven days before this infant surpassed his birth weight while in the first twenty-six days of life he gained a total of 10 ounces.

or, yellow; specific gravity, quantity not sufficient; albumen, negative; sugar, negative; diacetic acid, negative; white blood cells, 2 to 6; red blood cells, rare; casts, none; and bacteria, a few cocci.

Of interest might be the story of infant C. At three months this infant had a routine examination of the blood showing a red blood cell count of 2,750,000 with a hemoglobin estimation of 62 per cent. Because it was done for its statistical value, this count went unnoticed, and hence untreated, until the baby came in for a routine visit at six months of age. At this time, without any treatment whatsoever, the red blood cell count had risen to 3,750,000 and the hemoglobin estimation to 78 per cent. In contrast to this record, an older sibling while on hematinic therapy manifested a lesser rise in hemoglobin from 68 per cent to 74 per cent.

The advantages and disadvantages of such a revolutionary schedule, as related by the parents and hospital nurses and as observed by me, are as follows:

Advantages

1. These babies are much more contented; they are not taught to cry for a feeding at each awakening period. They quickly learn to lie in their cribs and amuse themselves.
2. They learn easily to eat from a spoon at an early age, a feat often difficult for a five to six months old child.
3. They accept new foods extremely well, because, in my opinion, they are introduced to them before they acquire likes and dislikes and because of a personal theory that any person will eat anything if he is hungry enough.
4. The practice of infrequent feedings is good insurance for good eating at a later date in life. I so frequently see children who have been started on a demand schedule and who later present feeding problems.
5. These babies have less frequent and better formed stools and are less given to bowel upsets.
6. These babies quickly learn to take large amounts of food without too much urging, sufficient to carry them from one feeding to the next.
7. The parents of such babies are happier parents because they realize that their babies are not fragile creatures and that feeding them both old and new foods is easier.
8. To a mother this offers the advantages of longer periods of rest and freedom between feedings.

9. With the early addition of foods, the necessity of vitamins and mineral supplements becomes optional and more often than not, unnecessary.

Disadvantages

1. It has been observed that initial weight gains according to standards, which in my estimation are empiric, are less rapid than with those babies on a more frequent feeding schedule. These weight discrepancies are later erased in the two to four months period.
2. The problem of crying at night in the first few weeks of life has been satisfactorily met by the addition of the midnight feeding and the 6 p.m. cereal feeding.
3. It takes more time to condition the mother to the acceptance of such a routine than it does for the acceptance of one of the older ideas.

Trials so far involve only cooperative and selected mothers. It is possible that observations may not be so favorable once the regimen is tried routinely on large groups of infants regardless of the temperament of the mothers.

Summary

In summary, it would seem from the foregoing that in presenting this radically new idea of baby feeding I have failed to make any contribution to the apparently long-established thought on this subject, but rather have added only fuel for further controversy and confusion. Such is not the intention. I am merely attempting to demonstrate that babies on infrequent feeding schedules do not suffer from such variations from the older regimens. It is my hope that I will eventually be able to demonstrate that babies do equally as well physically regardless of their feeding regimen. In doing so, it is my further hope that I will have contributed some little bit to the endeavor of creating more emotionally stable mothers and a lesser number of feeding problems in growing children without jeopardizing the health of the baby.

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Discussion

DR. EDGAR E. HITCHCOCK, Orlando: This paper has been most interesting, and I am more than delighted to hear this type of paper coming from a general practitioner. I wish to compliment Dr. Sackett on this presentation. He is dealing with a problem that is open to considerable criticism from pediatrician, allergist and obstetrician alike.

As I listened to this paper, several points came to mind that you as general practitioners may question, and I will endeavor to clarify these points.

As you have heard, Dr. Sackett is not following a self demand schedule of feeding the baby when he is hungry, but advocates a six hour schedule. No doubt, those of you who practice obstetrics wonder about the mother's breast on this schedule. Will she produce sufficient milk if the breasts are not emptied more often than six hours, since frequent emptying of the breast is the best stimulant to milk production? I think that I can answer this question in the affirmative by saying that most babies on self demand schedules who go from three to six hours on the breast usually do get sufficient breast milk for gratification, and the mother's breasts are no more painful as a rule.

The next question that is probably uppermost in your mind is, Can the newborn baby tolerate and actually digest food other than milk during the first months of life? As noted, Dr. Sackett introduced cereals at four to seven days, strained vegetables at one to two weeks and fruits at two to three weeks. Regarding the digestion of foods in the newborn Dr. Clement Smith, well known physiologist, stated that the normal newborn infant has a physical capacity for food which is unlikely to be exceeded by any ordinary dietary program. The enzymes present in the infant's system have not been found inadequate to deal with any type of food except complex carbohydrates. The infant has the greatest ability to assimilate proteins such as milk and meats. The reverse is true of fats, although the difficulty does not appear to be due to a lack of fat-splitting enzymes. Simple carbohydrates such as milk and cane sugar (disaccharides) and dextrose (monosaccharides) are easily assimilated by the infant at birth. Experience has shown that formulas based on high protein, low fat content with calories derived mainly from protein and carbohydrates are in all probability the most nourishing for the newborn infant.

Probably there will be some criticism from the allergist on the early introduction of solid foods. No doubt there is danger of sensitization to certain foods if introduced too early; yet there is also danger of overloading the hungry baby with too much milk. It is sometimes a problem whether we should feed rich milk formulas in abundance or take a chance on starting solids at an early date. Personally, I think there is less danger of sensitization by starting small amounts of cereal or other solids as the baby's appetite increases.

There are many advantages to a schedule like the one Dr. Sackett has presented. I agree with him that both baby and mother will certainly get more rest. As he has stated, the babies in his series did not gain too vigorously at first, but they soon made up for lost time. I believe Dr. Sackett's routine will work out in the normal infant, but think it will take a much larger series of cases to determine whether this routine should be tried generally.

I do not believe this routine will work out too well with the hypertonic infant who demands feeding every two to three hours, the allergic infant in whom one sensitivity after another develops, or the small infant weighing less than 6 pounds who has too small a feeding capacity to endure the six hour interval of feeding. This group of infants, however, will present a problem regardless of type of feeding.

As a constructive criticism of this paper, I would recommend that cereal not be offered at a specified age of four to seven days or strained vegetables at one to two weeks, but would rather let the infant decide and demand when he needs more food, other than breast or bottle, whether it be at two or four weeks. This plan might lessen the possibility of intestinal upset, regurgitation and early sensitization to foods.

Some Observations on the Interrelationships of Allergy and Diseases of the Chest

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Any wide discussion of allergy and diseases of the chest would assume encyclopedic proportions if it were not arbitrarily circumscribed and delimited. The ordinary typical clinical entities in each of these fields are fairly well understood, and by and large offer no unusual problems in diagnosis. These are seen by general practitioners, or via the latter by specialists in either field. Thus, the victims of these maladies reach proper hands for definitive management. The old rule-of-thumb, however, that "all is not asthma that wheezes," is occasionally overlooked, and it is well to be reminded that thorough study and care may be necessary before proper diagnosis and therapeusis can be achieved in these patients. Even the cursory view of the interrelationship of allergy and pulmonary diseases brings up one or two phases of this problem which may be worthy of consideration.

First we shall discuss the cold-and-cough susceptible child. This is the four-to-eight-year-old youngster who as a result of repeated protracted illnesses enters the office clinging to his mother. He is fidgety, pallid, wet-nosed, and quick; he rubs his nose with his thumb, forefinger, or palm, sucks back air and mucus into his posterior nasopharynx with a guttural, muted cluck, swallows visibly, and may give vent to a short, or even productive, cough. He has pale days and pink, complexion-wise, and unexplained fever. He is described as perspiring easily and "freely" particularly during sleep. Overheating from exertion or "playing too wildly," mother avers, "gives him all these colds," even though the brothers and sisters seem rarely to catch them by contact. Overeating, on the other hand, is never complained of; all patients of this type have finicky appetites. Laughing hard, running, or choking on a peanut, is enough to provoke paroxysms of coughing, wheezing, or the frank asthmatic seizure. The cold season, whether North or South, is his nemesis, and frequently Florida residence has been sought in the vain hope that "there he should do better." If he tends to run fever he may even have been sent South because of a suspected rheumatic state. Relaxed, pronated ankles, and myopic lenses, commonly round out the picture.

This clinical constellation is only too well known. Certain points, however, may be worth making even though they elicit heated disagreement. Children who present this picture are brought to doctors because they are sick, or have dis-ease in its primary meaning. The psychosomatic factors that have crept in are in the vast majority of instances after rather than before the fact. These youngsters have been mothered too much, and usually doctored too much, or at least more than was necessary had the true nature of their complaints been understood in the first place. The tonsillectomies and adenoidectomies, and the many medical consultations held when these operations failed of the desired result, have not contributed to the well adjusted personality. The unhelped child certainly did not make for a less anxious mother.

Assuming that food or inhalant allergy lies at the basis of the disorder, what is the mechanism in the clinical picture just outlined? The explanation is almost on a mechanical basis. Mucous membranes reacting allergically make mucus, and also become engorged and swell. If the organ lined by these membranes is hollow and possesses a muscular wall, the organ itself may go into spasm. This sequence of events is responsible for clinical allergic phenomena. The allergy in itself, or the reaction of the individual to physical or emotional changes, may each alone produce the symptoms. Concerning the specific response to known allergens there is no debate save when the question of "conditioned reflex" enters in. As regards the nonallergic phases, the symptomatology is almost pure mechanics.

Read in part at the Sixth Annual Meeting of the Southeastern Allergy Association, St. Petersburg, Jan. 20, 1951.

A certain amount of mucus is constantly present in the lumen of the bronchial radicles. An indraft of cold air, or sudden fluctuation of temperature, changes the relation of the bronchial wall to this mucus. Likewise, an emotional reaction, a hard laugh, or a sudden cough, may dislodge a previously quiet bit of mucus, or cause constriction of the bronchus onto the mucoid mass. Then follows cough, wheezing, or asthma, depending on the severity of the stimulus or of the reflex action. The effects are additive in that the mucus is present in a larger amount than normal because of the allergy, and the allergy not infrequently heightens the over-all physiologic irritability of the affected person. Further, if one can assume that all allergens are discovered and excluded, a much too optimistic assumption usually, the physiologic habit will remain for indeterminate periods of time after successful management of the allergy has been instituted. This serves simply to make the clinical picture even more complicated. Now, however, should a psychotherapist come along and resolve the environmental, and emotional, irritating factors to the point where the physiologic responses are reduced, the clinical improvement will then be said to justify the diagnosis of a psychogenic etiology. Only careful study and controlled observations can untangle the complicated skein of such a clinical history.

Going a step beyond this clinical entity to the chronic unexplained fever requires but a slight extension of the pathogenesis recounted. These infants and children who carry mucus around in their bronchial tree, at almost any given time have small segments of the lung obstructed by inspissated mucus with or without mild grades of bronchostenosis or spasm. If the plugs are not promptly dislodged, small areas of atelectasis develop, and when drainage is too long prevented, varying degrees of infection or autolysis with repair, or both, take place. This process is quite enough to cause fever, especially of low grade, and on occasion it may set up a frank pneumonia, as described by Friedman and his associates[1] and several others. The Balyeat group[2] reported the wedge-shaped shadow which they commonly find in these cases. It would appear that nature uses this mechanism to stop an asthmatic seizure, as so frequently a pneumonic febrile episode terminates status asthmaticus. This observation has led many to use induced fever as one of the methods of treatment in the more severe, unyielding types of asthma.

Postmortem examination in these types of cases in which death has occurred from accident, or an unrelated pathologic condition, has revealed the accumulations of mucus in the bronchial tree to which we have directed attention. We refer to the chronic, low grade fever, and the more acute type as well, as "plug pneumonitis" or "obstructive pneumonitis," whichever seems to fit the elegance of the moment. One must realize, too, that patients in this category may also have rheumatic or undulant fever, tuberculosis, Loeffler's syndrome, or blood dyscrasias. They may harbor parasites, abscessed teeth, or diseased tonsils. Hence, we cannot overemphasize the point that there is no substitute for complete, careful, rational clinical investigation and evaluation.

In adults this picture is further complicated by the ever present menace of neoplastic diseases of the lung, primary or metastatic. The first indication of a tumor of the lung, especially of the bronchus, may be a pneumonitis, an infection which may be cleared up by the use of antibiotics and/or sulfonamides. Alveolar carcinoma and lymphomatous disease of the lung may, in the allergic person, suggest Loeffler's syndrome, and one cannot afford to be caught off guard by failing to give these patients the benefit of thorough roentgen, endoscopic, and if necessary, biopsy investigation.

Therapy

If, after probing the chest complaints of the wheezing, dyspneic allergic patient, one returns to the initially presumptive diagnosis of asthma, what then is the guide to treatment? This is a large question, but one to which, for an audience of allergists, there are workable answers. We must assume that all discoverable allergic, structural, and infection factors have been reckoned with. Feathers and dust have been controlled, bronchostenosis and bronchiectasis have been ruled out, and the maximum possible cognizance of emotional elements has been taken. In the middle life and late life groups we must still be sure to determine the circulatory factors in the dyspnea. Has there been arteriosclerosis, hypertension, or coronary or cardiac valvular disease? If so, are these complicating the disease picture?

Of most help to us has been the simple calcium gluconate, or decholin (if patient has received digitalis), arm-to-tongue circulation time. In the emphysematous chest we have found this value to be 8.0-12.0 seconds, whereas in the cardiac dyspneas in which there is no doubt as to the cause, as in failure of the left side of the heart,

the time is 22.0 up to 34.0 seconds. The average normal is 12.0-18.0 seconds, and if in an asthmatic patient the measured time lies even in the middle of this range, we begin to suspect a circulatory factor. In such instances cardiac support may be indicated with digitalis or dehydration, as the case may be. Mercuhydrin is of great value in reducing congestion and lightening the load otherwise left for allergic management alone. If the strain on the right side of the heart has proceeded to great lengths and cor pulmonale is a growing problem, a sympatholytic or adrenergic blocking agent has been useful in some instances. We have used dibenamine[3] in this manner, as reported last year at the meeting of the American College of Allergists in St. Louis. This drug blocks the pressor and constrictor effects of adrenalin without interfering with its well known inhibitory effects, such as bronchial and coronary relaxation. In selected cases this drug has proved a useful adjunct to our therapeutic measures.

Of late, the appearance of ACTH and cortisone, and their availability for general use in allergic states, initially at least suggested that all refinements in therapy might quickly go into the discard. As more has been learned of these truly miraculous drugs, their limitations and drawbacks have also become more evident. It is true that on occasion these hormones produce a prompt and most satisfactory remission, but we are nevertheless left with the same primary problems that we had prior to the discovery of Kendall and Hench. We are learning that there is no royal road or easy path to successful diagnosis and treatment in asthma. All the investigative acumen of the observer must continue to be brought to bear on this age-old problem. The "cure" remains the desideratum, and seems most likely to be achieved through the sound pathologic physiologic approach which can only be derived through training and seasoned experience in this challenging field.

Summary

We have discussed some of the problems confronting the physician who deals with chest complaints and asthma in allergic children and adults. It is suggested that psychosomatic factors may stem from rather than produce the allergic complaint, and might be considerably reduced if the child gained the benefit of earlier, more accurate diagnosis and treatment. Unexplained fever in many of these youngsters has been found to be due to plugs of mucus obstructing small segments of the lung causing, in some instances, "plug" or "obstructive pneumonitis." In adults, however, one must be on the alert for neoplasms of the bronchi and lungs before establishing the diagnosis of allergic pulmonary disease.

In managing asthma in older adults, the measurement of the circulation time has been of great help in evaluating the role of hemodynamic factors, and in properly directing the treatment toward correction of fluid balance and of heart failure, in addition to the usual allergic therapeutic measures. In cor pulmonale the use of dibenamine, a sympatholytic, adrenergic blocking agent, has proved useful in selected cases. Despite the newer hormone drugs which are gaining wider use, the older therapies based on sound pathophysiologic principles, thorough training, and seasoned experience, are still the treatment of choice in the management of allergic diseases.

References

1. Friedman, T. B., and Molony, C. J.: The Role of Allergy in Atelectasis in Children, Am. J. Dis. Child. 58:237-249 (Aug.) 1939; Miller, H.; Piness, G.; Feingold, B. F., and Friedman, T. B.: Allergic Bronchopneumonia, J. Pediat. 7:768-790 (Dec.) 1935.

2. Bozalis, G. S.: Proceedings Balyeat Hay Fever and Asthma Clinic 20:11 (Nov.) 1950.

3. Klotz, S. D., and Bernstein, C.: The Use of Dibenamine in the Severe Asthmatic State and Related Chronic Pulmonary Conditions, Ann. Allergy 8:767-771 (Nov.-Dec.) 1950.

740 Magnolia Avenue.

MEDICAL DISTRICT MEETINGS

The Chairman of the Council, Dr. William C. Roberts, has announced that the dates of the Four Medical District meetings have been officially set by the Council.

Every member of the Association is urged to attend the meeting in his district and any of the other three meetings as desired.

Pensacola, Oct. 22, 1951

Bradenton-Sarasota, Oct. 24, 1951

Vero Beach, Oct. 25, 1951

Orlando, Oct. 26, 1951

ABSTRACTS OF MEDICAL ARTICLES

A POSITION OF VALUE IN STUDYING THE PELVIS AND ITS CONTENTS. By Gerard Raap, M.D. South. M. J. 44:95-99 (Feb.) 1951.

Dr. Raap observes that it seems scarcely conceivable that the Chassard-Lapine position has not been used and referred to more often in the voluminous literature on radiology since the French authors for whom it is named first described it in 1923. He states the conviction that it can be shown to have many uses. For example, in urology it will be of value in demonstrating the ureters and their relationship to the bladder with asymmetries due to adjacent tumor locations, and in hysterosalpingography it will give added information as to the shape and size of the uterine cavity and the location of the ovaries.

His chief interest, however, lies in its use with reference to the colon, particularly that borderline area between the realm of the radiologist and that of the proctologist, and he was unable to find previous mention of its use in this respect. The inclusion of at least one study of the colon in the Chassard-Lapine position has become a routine procedure in his work because of the fact that it often proves suspicious areas of incomplete filling to be normal, thereby making the diagnosis more positive than without it.



FAILURES IN MEDICAL TREATMENT OF PEPTIC ULCER, AN ANALYSIS OF INTRACTABILITY AS AN INDICATION FOR SURGERY. By Donald F. Marion, M.D. South. M. J. 44:148-153 (Feb.) 1951.

In a review of all operations for peptic ulcer performed during a recent twelve month period in two of Miami's larger general hospitals, intractable pain was the sole reason for operation in 20, or 29.4 per cent, of the 68 cases. The author cites lack of firmness on the physician's part and inability or unwillingness on the part of the patient to give intelligent cooperation as sharing responsibility to a considerable degree for failure of medical treatment. He notes that evaluation of the patient's inability to cooperate reveals a high incidence of both psychotic and seriously neurotic persons in this group. Also, he warns that a high incidence of suspicion must be maintained for hidden anatomic complications since in 60 per cent of the cases in this series such lesions were present at operation.

In view of the frequency of anatomic complications, Dr. Marion regards a standard or modified subtotal gastric resection as the procedure most likely to give prolonged freedom from pain and to restore a normal productive life to the patient. He believes that "intractability should not continue to be a wastebasket catch-all and an excuse for backing reluctantly into the operating room, but a comprehensively analyzed complication of peptic ulcer which receives the same thoughtful and skillful surgical treatment required by pyloric obstruction, acute and chronic perforation, and serious hemorrhage."



PAROXYSMAL VENTRICULAR TACHYCARDIA WITH SECOND DEGREE V-A BLOCK AND RECIPROCAL RHYTHM. By Sidney Grau, M.D., and James L. Gouaux, MD., Circulation 2:422-425 (Sept.) 1950.

A case of paroxysmal ventricular tachycardia with retrograde conduction is reported. The patient was an elderly white man in the terminal stage of arteriosclerotic heart disease. The electrocardiograms obtained during this period, representative portions of which are illustrated, were unique in that both reciprocal beats and fusion beats were noted during the tachycardia. The latter were unusual because of the origin and site of the fusion of the impulses within the ventricles. Also described and illustrated is a hitherto unreported abnormality of the retrograde P wave.

THE HEART IN FRIEDREICH'S ATAXIA. By M. Eugene Flipse, M.D., Thomas J. Dry, M.B., and Henry W. Woltman, M.D. Minnesota Med. 33: 1000-1003 (Oct.) 1950.

The literature is reviewed which emphasizes the involvement of the heart in Friedreich's ataxia, and 2 cases of this disease in association with myocarditis, occurring in brothers aged 18 and 12, are reported. An absence of tendon reflexes and an extensor response of the plantar reflex, the two neurologic signs most frequently observed in patients with electrocardiographic abnormalities, were present in both cases. These cases represent another example of the observation that afflicted members of one family tend to have similar electrocardiographic patterns.

The authors offer no explanation for the more pronounced electrocardiographic changes present in the younger patient, in whom neurologic damage was less evident, but they emphasize it because it is contrary to previous experience. In this latter case, there was extension of electrocardiographic abnormalities across the entire precordium, a finding which further supports the belief that most, if not all, of the cardiac abnormalities associated with Friedreich's ataxia are due to a diffuse myocarditis, of unknown but probably toxic origin.

A NEW APPROACH TO THE TREATMENT OF SUBCAPITAL AND TRANSCERVICAL FRACTURES OF THE HIP, PRELIMINARY REPORT. By Eugene L. Jewett, M.D., F.A.C.S., F.I.C.S. J. Internat. Coll. Surgeons 14:403-419 (Oct.) 1950.

Dr. Jewett reports on a method of treating subcapital and transcervical fractures of the hip in which he initiated the use of a one piece of flanged hip nail for fractures about the trochanteric region. After trial of a year and a half, he finds the results promising. The series of 14 consecutive cases represents approximately one fourth of the 54 cases of fracture of the femoral neck or the trochanteric area in which he has operated during this period. He explains the cardinal points which justify use of this nail and presents roentgenograms of the entire series.

URETERAL INJURY COMPLICATING FRACTURE OF THE BONY PELVIS. By Arthur J. Butt, M.D., and Joseph Q. Perry, M.D. South. Surgeon 16:1139-1142 (Dec.) 1950.

The lack of a "typical" early picture of ureteral injury complicating pelvic fracture may account, in the opinion of these authors, for the few cases of this type reported in the literature, and their true incidence is possibly greater than is generally assumed. In the case of ureteral injury complicating pelvic fracture which they report, apparently the ureteral and periureteral tissue at the level of the pelvic brim was contused and lacerated by fractured bones, and a dense periureteritis and ureteral stricture, producing hydronephrosis and hydroureter, developed. Plastic repair of the ureter was deemed impossible; the kidney and upper two thirds of the ureter were therefore removed.

CLINICAL EXPERIENCE WITH CROWE'S VACCINE IN THE COMBINED MANAGEMENT OF ARTHRITIS. By Kenneth Phillips, M.S., M.D. South. Med. & Surg. 113:68-71 (March) 1951.

In the opinion of this author Crowe's vaccine presents a well tried and valuable measure at the hands of the general physician to combat rheumatic disease. In his experience it stands out as first choice of any single measure in the management of this disease. Its value, however, will be in direct ratio to the amount of attention paid to the basic concepts and technic in its use, which he discusses. When lack of response is evident, he favors combination with sulfur, gold, physical or fever therapy to effect a definite gain in symptomatic relief. Cortisone, while observed by him for only a short time, has proved itself, at least temporarily, superior in the true rheumatoid type; it has not equaled the other measures in either the mixed or nonrheumatoid cases. Physical therapy is a valuable adjunct in many cases, he noted; when indicated, it should be used in combination with other selected measures. Fever therapy, by electromagnetic induction, in short sessions, will often supplant other physical measures when many joints are involved, but as a specific, it has shown no value in his hands except in arthritis of gonorrheal origin.

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VOLUME XXXVIII
NUMBER 2

The Journal of the Florida Medical Association

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August Anniversaries

AUGUST 1. Joseph Priestley isolated oxygen on Aug. 1, 1774. A voluminous writer with a passion for experimentation, this ardent nonconformist clergyman was the founder of the Unitarian Church in the United States.

Although Priestley did not perceive the true nature of respiration, he told Lovoisier of his experiments with oxygen. Later, Lovoisier settled the question.

AUGUST 1. John Collins Warren was born on Aug. 1, 1778 and died on May 4, 1856. In contrast to his father, Dr. John Warren, who had only apprentice training, Dr. John C. Warren had the advantage of study in London, Edinburgh and Paris. Parallel to the work of his father, who founded the Harvard Medical School, Dr. John C. Warren founded the Massachusetts General Hospital in 1821. It was he who made it possible for Morton to try ether anesthesia on patients undergoing general surgery.

AUGUST 2. John of Gaddesden, England, who lived during the thirteenth and fourteenth centuries, was probably the original of Chaucer's Doctor of Physic. John's training at Merton College, Oxford, which embraced four years of study after the M. A. degree and included much practice in Latin disputation, did not require that he watch even one dissection, see a single patient, or do one bit of clinical work. John, however, became a popular practitioner as well as physician to Edward II. He was appointed to a stall in St. Paul's Cathedral on Aug. 2, 1342. It was prior to that time that he was chosen by Chaucer as a member of that oddly assorted company which assembled at the Tabard Inn in Southwark on the old Roman road for the pilgrimage to Canterbury. In later years John found time, despite a large practice, to write a popular medical text, Rosa Medicinae or Rosa anglica, made up largely of kitchen lore, superstitions and medical quotations.

AUGUST 11. Richard Mead of London, born on Aug. 11, 1673, was the second possessor of the famous gold-headed cane, bequeathed him by Radcliffe. Scholarly, courtly, popular and wealthy, Dr. Mead was physician to Queen Anne and to George II. He made a study of smallpox inoculation in 1721, three quarters of a century before Jenner's work. He might be called the father of English quarantine, for believing the plague at Marseilles, France, to be contagious, he induced the English government to establish its first quarantine. Among other outstanding accomplishments, he persuaded the wealthy citizen, Guy, to establish the famous hospital named after him.

On disarming "Dr. Woodward," a colleague, in a duel, Dr. Mead exclaimed, "Take your life!" Woodward is said to have responded, "Anything but your physic."

Dr. Samuel Johnson said, "Dr. Mead lived more in the broad sunshine of life than almost any man."

August 24. Pliny the Elder, Gaius Plinius Secundus, greatest of Roman natural philosophers, was born in the first quarter century after Christ and died in the eruption of Vesuvius on Aug. 24, A.D. 79. Pliny was a student in the true sense of the word. He always made notes when he read, he had a servant read to him while he bathed, dressed and ate, and he had a secretary at hand almost constantly who took dictation on wax tablets. He wrote voluminously on diverse subjects, leaving to posterity a thirty-seven volume Natural History notable for the section which deals with zoology. Pliny was an outstanding student of medical botany. In philosophy he was a "modified stoicist;" in his view of nature he was pantheistic. His nephew and heir, Pliny the Younger, described his uncle's death in a letter to Tacitus; hence we know the date and circumstances of his death. To watch the eruption of Vesuvius more carefully, Pliny and a group of friends landed from a ship on the south shore of the Bay of Naples. Apparently to escape the approach of fire, ashes, lava and showers of stones, Pliny lay down on the seashore. His body was found free from burns or other injuries. Apparently he had been suffocated by fumes.

August 29. Oliver Wendell Holmes, physician, poet and Autocrat of the Breakfast Table, was born in Cambridge, Mass., on Aug. 29, 1809. His great contribution to the medical world is his essay, "On the Contagiousness of Puerperal Fever," read on Feb. 13, 1843, before the Boston Society for Medical Improvement and published that year in volume I of the New England Quarterly Journal of Medicine and Surgery. This paper is a milestone in the history of medicine and in the attitude of physicians toward infection.

Puerperal fever had been recognized from the earliest days of medicine. Hippocrates and Galen both were acquainted with the symptoms and signs of the disease.

At about the time Dr. Holmes was collecting material for his essay, a young undergraduate in medicine in far-off Vienna, Ignaz Philipp Semmelweis, was making independent observations on the contagiousness of puerperal fever. In 1847, four years after Dr. Holmes presented his essay, Dr. Semmelweis composed his first treatise on the subject.

To Dr. Holmes, of course, goes the honor of priority, but Dr. Semmelweis deserves to have had his name made famous because of his recognition of the disease as a septicemia and because of his unceasing teaching. Dr. Frank Slaughter in a recent historical novel, "Immortal Magyar," has given full impact to the drama and tragedy which enveloped Dr. Semmelweis' life, particularly toward its end.

After Dr. Holmes had brought forth strong proof of the contagiousness of puerperal fever, his views were not readily accepted by many. He was attacked by the two leading obstetricians of Philadelphia, Drs. Meigs and Hodge, who believed that "irregularity of diet, a confined state of the bowels" or "atmospheric changes" were responsible for the disease.

Because of the small circulation and early discontinuance of the journal in which his paper was published and because of the controversy which was aroused, Dr. Holmes had his paper republished in 1855, the introduction to which every student of medicine should read.



Very truly yours
Oliver Wendell Holmes.

(Courtesy: Volume I, Medical Classics, Baltimore, The Williams & Wilkins Company.)

Sir William Osler once asked Dr. Holmes whether he valued more his paper on puerperal fever or his poem, "The Chambered Nautilus." Replied Dr. Holmes, "There is . . . a nobler satisfaction from the life-saving labor."

Hungary has honored Dr. Semmelweis by removing his ashes from Vienna and burying them with ceremony in Budapest and by erecting in one of the public squares of Budapest a fine monument to its son. The United States has yet to honor Dr. Holmes befittingly.

The Korean Medical Experience

Once they reach medical care, fewer wounded American soldiers are dying in Korea than in World War II. The mortality now appears to be less than 2½ per cent as compared to 4 per cent in World War II. The rate in World War I was approximately 8 per cent.

This lowered death rate is attributed in part to the increased number and further uses of the antibiotics, such as penicillin, chloromycetin, aureomycin, streptomycin and terramycin. During World War II, penicillin was the only one of these drugs available, and it was not available throughout the entire Army medical system until late in the war.

Transfusion of whole blood is also a contributing factor in the lowered mortality. First used in the last war, whole blood has been available since the beginning of the Korean operation and is administered in the forward areas. Dextran, polyvinylpyrolidone and gelatin are being used to combat shock due to injury, but these substitutes can never replace blood plasma or whole blood.

Methadon, a synthetic morphine substitute, has been proved to have, dose for dose, the same pain-killing effect as morphine and also causes far less nausea and vomiting. Chloroquin, the new drug to combat malaria, is proving effective as a suppressant and much more desirable than atabrine. It is given only once a week. While it does not produce clinical cure of malaria, it is effective against the malaria-bearing parasites in the blood stream. The Army is also testing primaquin, another new drug, with the expectation that it will effect clinical cure.

A new type of dressing for extensive body burns, a pad 3 by 2 feet, has on the side touching the patient a fine gauze covering backed up by many sheets of an impermeable material resembling facial tissue. Also receiving extensive testing is a bandage with a two way stretch which is chemically treated to make it self adhering.

ACTH is being used in the treatment of burns and frostbite, and in wounds where the nerves have been injured. Scar tissue, which makes surgical repair of nerves difficult, is prevented by ACTH.

These highlights of the Korean medical experience were presented before the recent convention of the American Pharmaceutical Manufacturers' Association in Boca Raton by Col. Lawrence A. Potter of the Army Surgeon General's Office, whose comprehensive article entitled "What Medicine Has Learned in Korea" was published in the April issue of the Journal of the American Pharmaceutical Association.

A Decade of Health Progress in Florida

Tremendous progress was made in the general field of health in Florida during the period from 1940 to 1949. The highlights of the picture presented by Dr. Wilson T. Sowder, State Health Officer, at the annual meeting of the Association in April should afford great gratification to every member.

A highly significant evidence of progress was the 15 per cent decline in the over-all death rate. Down in varying and in some instances truly remarkable degree were the maternal and infant death rates and death rates from infectious diseases and other causes. The mortality from diphtheria, whooping cough, typhoid fever, dysentery, malaria and typhus fever (combined) was down appreciably. The decrease by one half in the death rate from tuberculosis was in contrast to a considerable increase in the death rate from cancer.

The great decline in mortality from syphilis caused it to be replaced by diabetes in the first ten causes of death. The death rate from pneumonia and influenza also greatly decreased. That the combined mortality from cardio-vascular-renal diseases did not increase suggests, as Dr. Sowder observed, that in some measure the increase in heart disease may be due to changing fashions in diagnosis.

There was a gratifying decrease in the motor vehicle accident death rate and also in the mortality from other accidents.

The increase in hospital beds about paralleled the increase in population. Here the increase of 117 per cent in the number of bassinets and of 91 per cent in the number of beds for tuberculous patients is particularly noteworthy.

While the problems of the decade of the fifties are pressing and offer abundant challenge, nevertheless the accomplishments of the forties may well be a source of great pride to Dr. Sowder, his staff and the members of the Association. They provide ample incentive for the future.

Novel Diagnostic Method

A good way to discover what is wrong with patients is to imitate them. This "diverting, medically useful, life hobby" was described in California Medicine for January 1950 by Dr. C. M. Cooper, retired professor of clinical medicine at Stanford University. Imitating the gestures, postures and facial expression of patients and then figuring out what would produce them might be as profitable a diagnostic procedure in Florida as in California.

There was the patient who thought he had gallstones. When he got down on his hands and knees and inclined his body to demonstrate the position which relieved his pain, Dr. Cooper did the same, imitating his every movement. His conclusion that the posture he had assumed seemed more calculated to afford some relief from pain originating in the kidney rather than in the gallbladder was confirmed by roentgen examination. Imitating a patient's expression, gait or idiosyncrasies afforded valuable clues to other illnesses.

Told early in his career that he was a poor clinical observer, this resourceful physician began dividing up a patient's face into sections, examining each section individually. Soon he was catching expressions that formerly eluded him. If he could not arrive at their meaning, he would imitate them before a mirror. Then would come realization of what inner feeling in him would have called forth such an expression, and in all likelihood in the patient exhibiting it. Before long he was imitating the tone, placement and tempo of the speaking voice and eventually the behavior reactions of his patients.

Revealing experiences with patients made it but a step to extend these activities into the imaginative or experimental fields. "Thus I would imagine I had a particular symptom or ailment that puzzled me," said Dr. Cooper, "and then see if I could uncover anything in my past that might cast light upon it; or that I had a patient's crippling impairment for which he had not been able to evolve a helpful compensatory adjustment; and then try through self experimentation to unearth one for him."

Putting himself in the patient's place, so to speak, might well prove stimulating physical and mental gymnastics for the clinician. Too, this vicarious approach to the patient's problem might greatly increase his diagnostic acumen.

The War Prisoner Medical Burden in Korea

American medical personnel in Korea has indeed had thrust upon it "an unusual burden" in giving outpatient and hospital care to more than three quarters of a million enemy prisoners of war. The Department of the Army has announced that in a recent six month period Army hospitals in Korea received as patients 37,000 North Korean and Chinese Communists, in addition to 800,000 given outpatient treatment.[1] To another 179,416, vaccinations and immunizations were administered. Despite this monumental task, the mortality among hospitalized enemy prisoners was only 7 per cent, as compared with a death rate of 8 per cent among American wounded receiving medical attention in World War I. Yet the Army report states that "great complications" were present in a majority of enemy cases treated.

The many diseases encountered among the enemy troops, the apparent indifference of the enemy to caring for battle casualties, the low and often nonexistent standards of medical care provided by the enemy for their own casualties, little or no provision for drugs, equipment or evacuation of casualties, utter indifference to the value of human life with wounded men left to die without treatment of any kind, all of these factors greatly enhanced the difficulties of the United States Army Medical Service. Even at best, says the report, standards of treatment have been low in the Communist forces, with undergraduate medical students serving in most medical officers' positions.

1. Care of War Prisoners in Korea, J. A. M. A. 146:13 (June 23)1951.

The Florida Cancer Council

It has become increasingly apparent to many physicians of Florida engaged in the various aspects of cancer work that there is a need for an over-all co-ordinating body to unify and help determine the shape and direction of cancer control in Florida. One phase of the cancer control program has been administered by the Florida State Board of Health, another has been handled by the Florida Division of the American Cancer Society, and some phases have not been attended to by any agency. There has been no direct tie-in between the American Cancer Society, the Florida State Board of Health, and the Committee on Cancer Control of the Florida Medical Association. In short, the cancer control program of Florida has been deprived of its maximum effectiveness because of the lack of co-ordination and direction.

In 1950, representatives of the Committee on Cancer Control of the Florida Medical Association, the Florida State Board of Health, and the American Cancer Society, realizing these deficiencies, began to discuss the desirability of forming an over-all committee which would correlate and give direction to the cancer control program of the state. About the time these plans began to take form, a letter came from the American College of Surgeons suggesting that, if no statewide cancer control committee existed in Florida, one be set up by the College. The reasons establishing the desirability of this committee were set forth by the College and these reasons coincided exactly with what those of us in Florida had been thinking. Many states, notably Texas and New Jersey and our neighboring state of Georgia, had already organized cancer control committees which were functioning to the advantage of these various states.

With this encouragement, a definitive plan was formulated in Florida which envisioned a seven man committee to act as a statewide cancer control committee. The membership was constituted as follows: two members from the Florida State Board of Health, two members from the Committee on Cancer Control of the Florida Medical Association, two members (physicians) from the Florida Division of the American Cancer Society, and one member representing the American College of Surgeons. In order to avoid confusion with any existing cancer committee, it was decided that the committee would be called the Florida Cancer Council. Each participating organization has since approved the Florida Cancer Council and named its representatives. The Council became official when approved by the Florida Medical Association at its annual meeting in Hollywood in April 1951.

The present membership of the Florida Cancer Council is as follows:

Representing the American Cancer Society

Dr. Ashbel C. Williams, Jacksonville, President, Florida Division, Chairman*

Dr. C. Frank Chunn, Tampa, Director, Tumor Clinic, Tampa Municipal Hospital

Representing the Florida Medical Association

Dr. Frazier J. Payton, Miami, Chairman, Committee on Cancer Control

Dr. George W. Morse, Pensacola, Member, Committee on Cancer Control

Representing the Florida State Board of Health

Dr. Wilson T. Sowder, Jacksonville, State Health Officer

Dr. Lorenzo L. Parks, Jacksonville, Director, Cancer Control Program

Representing the American College of Surgeons

Dr. Duncan T. McEwan, Orlando

The Council is working on a Cancer Control Program for Florida at the present time. The various phases of this Program will be presented in The Journal as each phase is completed. The help of and suggestions from all the physicians of Florida are earnestly solicited by the Council. Already the Council has brought about a spirit of cooperation amongst its parent organizations.

It is hoped that the efforts of the Florida Cancer Council will meet with maximum success and that every physician in Florida will do his bit to make the Cancer Control Program outstanding. The Florida Cancer Council needs the understanding and support of every member of the Florida Medical Association in order to carry out its program and attain its objectives.

*Chairman elected by the members of the Council.

The National Fund for Medical Education

In a determined effort to meet voluntarily the critical financial needs of the nation's hard-pressed medical schools, industry, organized labor, agriculture, universities and scientific and educational foundations have recently joined hands with the medical profession. Establishment of the National Fund for Medical Education was announced in New York in May at the annual meeting of the sponsoring group.

The board of trustees of this important new organization is composed of 66 of America's most distinguished leaders. Former President Herbert Hoover is serving as honorary chairman and Mr. S. Sloan Colt as president. Mr. Colt is the president of the Bankers Trust Company of New York. On the 20 man advisory council are presidents of leading universities and members of the Council on Medical Education and Hospitals of the American Medical Association and of the executive council of the Association of American Medical Colleges.

The Fund has for its chief objective the raising annually of substantial sums from voluntary sources in order to relieve the acute problem faced by medical schools as they endeavor to maintain high academic standards in the face of crippling budgetary problems. The goal for the first year is $5,000,000, and emphasis is being placed on obtaining contributions from corporations and organized groups, now the great potential source of philanthropy in this country. In announcing the Fund after two years of careful planning and organization, Mr. Colt stated that the initial support had come from a wide spectrum of the American community, including contributions from the medical profession and such other groups as 18 leading life insurance companies and many industrial corporations, providing starting resources of more than $1,000,000.

A minimum goal of $1,000,000 is suggested for the medical profession for this year as evidence of its willingness to meet its responsibilities in this combined effort. Anticipating the day when the profession would be called upon to participate in this project, the American Medical Association last December appropriated $500,000 as a nucleus for the profession's 1951 contribution and at the Cleveland meeting sponsored the founding of the American Medical Education Foundation, through which individual physicians and state and county medical societies could make their contributions. The Foundation has announced that it will channel its contributions from physicians through the Fund, thereby demonstrating the importance it attaches to this movement and the confidence it has in its success.

Physicians are expected to continue making their contributions to the American Medical Education Foundation, 535 N. Dearborn St., Chicago 10. These contributions to the Foundation will be turned over in lump sums to the Fund, which is not assuming the responsibility of handling the individual contributions. A novel feature of the Fund's machinery is that every dollar in contributions flows directly into medical education because the administrative costs of the Fund have been underwritten by a number of foundations; also, appropriate provision has been made for equitable distribution of the money. The arrangements between the Foundation and the Fund make full and adequate provision for handling directed contributions. Physicians may continue to designate the school to which they wish their contributions to go and may be assured that the schools will be notified of the names of the contributors and the amounts contributed.

The Fund now provides the vehicle through which all who are concerned for the welfare of the nation's medical schools, whether organizations, groups or individuals, may assist in solving this vital problem. While the medical profession continues aggressively its intensive effort to do its part in this nationwide drive to meet the needs of the medical schools on a national basis, individual physicians can render important service not only by contributing liberally but also by encouraging lay interest, especially among officers of companies and corporations.

Pertinent lay comment follows:

Mr. Hoover characterized the organization of the Fund as a "significant development in the strengthening of the nation's medical manpower."

Dr. James B. Conant, President of Harvard University: "One of the Fund's most appealing features is that it has brought together men of widely differing backgrounds and personal viewpoints to concentrate their energies on a problem which, if left unattended, may well help to destroy many of America's private universities."

Dr. Harold E. Stassen, President of the University of Pennsylvania: "Doctors are on the front lines of our national defense effort and they must

be competently trained along present high standards if we are to maintain our leadership in world affairs."

Mr. Colt: "The Fund is a fine example of practical democracy at work. . . . What is most gratifying and significant is the fact that this vital project has brought together as trustees a broadly representative group of men and women. Those who organized the Fund may have differing social viewpoints but, insofar as the Fund is concerned, we have united in an endeavor to solve a serious problem for the common good. Unless the medical schools are given financial help, and given it quickly, the standards of medicine may be permanently impaired and the nation's health affected adversely."

Postgraduate Medical Education

A course in Hematology presented by the Department of Medicine of the Graduate School of the University of Florida was given by Dr. Charles A. Doan, Dean and Professor of Medicine at the Ohio State University College of Medicine, Columbus, Ohio, June 21-23, 1951, at the George Washington Hotel in Jacksonville. Registration for this course was 81. The interest in the course was keen. Dr. Doan was an enthusiastic lecturer holding his audience throughout the entire period.

* * *

The Nineteenth Annual Graduate Short Course, meeting June 25-30, 1951, was also held in Jacksonville at the George Washington Hotel. The registration was 171.* The lecturers were excellent and well received by those in attendance. Dr. A. A. Marchetti, the lecturer on Gynecology, had an unfortunate accident to his knee and was unable to attend. Dr. Bayard T. Carter, Professor of Obstetrics and Gynecology at Duke University School of Medicine, Durham, N. C., agreed to substitute at the last minute. He took the subjects already assigned to Dr. Marchetti. The Committee regrets deeply that Dr. Marchetti could not be present and is most grateful to Dr. Carter for coming to the rescue so ably.

*Thirteen Negro physicians.

YOUR BLUE SHIELD

Blue Shield Name Becomes Official

The official names of the Florida Blue Cross and Blue Shield Plans have been changed from Florida Hospital Service Corporation and Florida Medical Service Corporation to Blue Cross of Florida, Inc., and Blue Shield of Florida, Inc., respectively.

The change became official and effective on June 19, when amendments to the charters of both plans, proposing to change the names of the corporations, were approved by Judge Bayard S. Shields, Circuit Judge of Duval County, and recorded in the office of the Clerk of the Circuit Court for Duval County. Prior approval of the amendments had been received from the Insurance Department of the State of Florida.

The name change will in no way affect the administration of the Plans, and has no significance other than the inclusion of the terms "Blue Cross" and "Blue Shield" in the official names of the corporations.

Such a step had been under consideration for several months by the Boards of directors of the two plans because of the common useage and close association of the terms "Blue Cross" and "Blue Shield" with the two health care plans, and because of the advisability of registering these terms and their identifying emblems with the Secretary of State as protection against possible use by other parties.

The term "Blue Cross" and the Blue Cross emblem signify the seal of approval of the American Hospital Association which is given annually only to those non-profit, voluntary hospital care plans which meet the standards set up by that association. The Florida plan has received the American Hospital Association's approval each year since its organization in 1944.

"Blue Shield" is a similar identification for the voluntary, non-profit medical care plans.

In order to eliminate any expense in connection with the name changes, the printed forms and letterheads showing the former names of the two corporations will be used until the present supply is exhausted.

STATE BOARD OF HEALTH

Immunization Procedures

The State Board of Health is frequently called upon by physicians of the State and County, and Health Directors, for an immunization schedule for various age levels. The State Board of Health has recently prepared a schedule for immunizations. The schedule in the table below is recommended provided alum precipitated or alum hydroxide absorbed is used. The schedule is submitted as information for the readers of The Journal.

The State Board of Health is attempting to purchase biologicals whereby the standard dosage will be 0.5 cc. The dosage in some products may differ from this amount. This schedule was designed to fit the need of Health Officers doing mass immunizations and may not necessarily fit the needs of private physicians who are able to give more individual attention to each patient.

Recommended Immunization Schedule

Biologicals	Age	Dose	Booster
Diphtheria, Pertussis, Tetanus } DPT	2-4 months up to 5 years	0.5 cc.—3 doses one month apart	12-18 months after completed series. 2-3 years later and again in 3 years
Diphtheria, Tetanus } DT	2-4 months up to 5 years	0.5 cc.—2 doses one month apart	Use single antigen
Diphtheria Toxoid	2-4 months up to 8 to 10 years	0.5 cc.—2 doses one month apart	One year later and/or on admission to school
Pertussis Vaccine	2 months up to 6 years of age	0.5 cc.—3 doses one month apart	3 or 4 years later up to 6 years of age
Tetanus Toxoid	2 months up to any age	0.5 cc.—2 doses one month apart	1 year after series and every 3-4 years after injury
Smallpox	Preferably after DPT and at all ages		Every 3-4 years and on exposure
Typhoid	Not recommended routinely except in endemic areas and upon exposure	0.5 cc.—3 doses 1 to 3 weeks apart	Every year

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Asher, Leo A., Jr., Miami
Beller, Harry E., Miami
Breakstone, Judd R., Miami Beach
Cole, Benjamin M., Orlando
Feldman, Leon R., Miami
Griffitts, John J., Miami
Hasty, Frederick E., Coral Gables
Kaye, Harry D. L., Miami
Rudolph. Jack A., Miami Beach
Shapiro, Richard D., Miami Beach
Turnley, William H., Ocala
Verdon, Franklyn E., South Miami

BIRTHS AND DEATHS

Births

Dr. and Mrs. David Kirsch of Miami announce the birth of a daughter on June 15, 1951.

Dr. and Mrs. Daniel R. Usdin of Jacksonville announce the birth of a daughter, Lauren Harriet, on June 18, 1951.

Dr. and Mrs. Maurice I. Edelman of Miami Beach announce the birth of a daughter, Denise Gail, on June 25, 1951.

Deaths — Members

Howard, Everett E., Gainesville ..... May 14, 1951
Jones, Gerald W., Orlando ..... June 5, 1951
McGunagle, Joseph E., Miami ..... June 5, 1951
Powell, Jay A., West Palm Beach ..... July 2, 1951
Counts, Herbert W., Jacksonville ..... July 4, 1951

Deaths — Other Doctors

Kenworthy, William B., Lake Worth ..... March 19, 1951

STATE NEWS ITEMS

The annual district meetings for 1951 have been scheduled as follows: Northwest District A at Pensacola, October 22; Southwest District C at Bradenton-Sarasota, October 24; Southeast District D at Vero Beach, October 25, and Northeast District B at Orlando, October 26.

The program for these meetings will be arranged by Dr. William C. Roberts of Panama City, chairman of Council. He will be assisted by the eight councilors and the secretaries of the cooperating county medical societies. The complete program will appear in a later issue of The Journal.

The Southern Medical Association has scheduled its forty-fifth annual meeting at Dallas, Texas, Nov. 5-8, 1951.

Members of the Florida Medical Association who will participate in the meeting include Dr. Walter C. Jones, Miami, first vice president; Chadbourne A. Andrews, Tampa, councilor; Sullivan G. Bedell, Jacksonville, chairman of the section on neurology and psychiatry, and J. Randolph Perdue, Miami, chairman of the section on gynecology.

Dr. Joshua C. Dickinson of Tampa served as chairman of the section on radiology at the 1951 annual meeting of the American Medical Association, Atlantic City, June 11-15.

Dr. DeWitt C. Daughtry of Miami has recently been elected president of the Florida Chapter of the American Trudeau Society.

Dr. Paul W. Hughes of Fort Lauderdale on June 25 addressed the West Hollywood Citizen's league on the subject, "Health and Sanitation for Unincorporated Areas."

Dr. John T. Stage of Jacksonville was the guest speaker at the Gainesville Rotary luncheon on June 20. Dr. Stage spoke on the history of anesthesia.

Dr. Maurice I. Edelman announces the opening of his offices at 515 N. E. 15th Street, Miami. His practice will be limited to Ear, Nose, Throat, Bronchoscopy and Plastic Surgery.

Dr. Robert H. Hutchinson of Tallahassee recently addressed the Florida State Nurses Association on the contributions of early orthopedic physicians.

Dr. M. Austin Chardkoff of Tampa has returned to his practice following a visit to medical clinics in Chicago.

Dr. Donald W. Smith of Miami served as chairman of the dedication committee of the Dade County Cancer Institute, which was held on July 2-3.

Dr. F. Gordon King of Jacksonville recently received his Master of Medical Science in Surgery degree at the University of Pennsylvania.

Drs. Gunnard J. Antell and Wesley S. Nock announce the opening of new offices at 273 Alhambra Circle, Coral Gables. Their practice will be limited to pediatrics.

Dr. Jack L. Wright of Miami has returned to his practice following a tour of active duty as a reserve officer with the Navy Medical Corps. He was released to inactive duty June 10, 1951 with the rank of Lieutenant Commander.

Dr. Philipp R. Rezek of Miami presented a paper, "Hormonal Influences upon Cancer of the Prostate," before the recent meeting of the International Association of Medical Pathologists which was held in London.

Dr. Sullivan G. Bedell, Jacksonville, spoke to the Big Brothers at a recent luncheon meeting at the local First Christian Church.

Dr. Hubert A. Barge of Miami was recently honored by being chosen the "outstanding alumnus of Mercer University for 1951."

Dr. Arthur J. Butt of Pensacola was guest speaker at the National Colloid Symposium held recently at Cornell University, Ithaca, New York. He spoke on "Importance of Urinary Colloids in Prevention of Kidney Stones."

Effective June 7, Mrs. Arthur E. Curtis will be full-time Field Representative of the Association's Bureau of Public Relations to work in Southwest and Southeast Medical Districts. For the past two years, Mrs. Curtis has been on a half-time basis in the Dade County area.

Dr. Edward V. Pollard of St. Petersburg on June 7 addressed the graduating class of the Mound Park School of Nursing.

Dr. Harold E. Winchester of Dunedin conducted a quiz program at the regular meeting of the local Rotary Club on June 7.

Dr. Robert J. Jahn of Winter Haven recently addressed the meeting of District 12, Florida State Nurses Association, which was held at the Winter Haven Hospital. Dr. Jahn discussed new drugs and various ways of administering them.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

WANTED: Recent medical school graduate with one or two years internship for employment in office of general surgeon in central Florida. Write 69-52, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: New W-666 Castle Autoclave 8"x16", $250.00; chrone outside; steam jacket; bronze cast body; double Full-Automatic control (pressure and low water cut-off). Contact John F. Mason, M.D., 120 Walcaid Building, Bradenton, Fla.

COMPONENT SOCIETY NOTES

Dade

The Dade County Medical Association held its regular monthly meeting at the Miami Woman's Club on July 3. The program included a symposium on cytology.

Escambia

Members of the Escambia County Medical Society participated in the annual Escambia Medical Assembly held in Pensacola June 15. This yearly medical program is held in conjunction with the Fiesta of Five Flags. Speakers on the full day program included Drs. Raymond B. Squires, Alpheus T. Kennedy, Alwyn W. White, William J. Overman and Pascal G. Batson, Jr., all members of the society.

Guest speaker was Dr. R. L. Sanders, professor of surgery at the University of Tennessee College of Medicine.

Marion

At the regular monthly meeting of the Marion County Medical Society on June 19, Dr. Robert B. McIver, president-elect, spoke on "Congenital Anomalies."

Orange

All members of the Orange County Medical Society have paid their state dues for 1951.

MEDICAL DISTRICT MEETINGS

The Chairman of the Council, Dr. William C. Roberts, has announced that the dates of the Four Medical District meetings have been officially set by the Council.

Every member of the Association is urged to attend the meeting in his district and any of the other three meetings as desired.

Pensacola, Oct. 22, 1951

Bradenton-Sarasota, Oct. 24, 1951

Vero Beach, Oct. 25, 1951

Orlando, Oct. 26, 1951

OBITUARIES

George Lewis Hardgrave, Jr.

Dr. George Lewis Hardgrave, Jr., of Jacksonville was killed in a plane crash on Iwo Jima on April 22, 1951. He was 34 years of age. Interment took place in Clarksville, Ark., on June 1.

A native of Arkansas, Dr. Hardgrave was born in May 1916 in Clarksville, where his father, Dr. George Lewis Hardgrave, Sr., is still engaged in the practice of medicine. After graduation from the Clarksville High School, he received his premedical training at the College of the Ozarks and the University of Arkansas, where he received the degree of Doctor of Medicine in 1942.

Upon completion of an internship at St. Luke's Hospital in Jacksonville, Dr. Hardgrave reported for active duty with the United States Navy in 1943, serving in the Caribbean, Mediterranean and North Atlantic theaters. He completed his training as a flight surgeon in Pensacola in 1944 and served as flight surgeon at Litch Field until his separation from the service in 1946.

Following his military service, Dr. Hardgrave returned to Jacksonville to enter the private practice of surgery. From July 1946 to July 1947 he served as extern in surgery at St. Luke's Hospital.

On Dec. 5, 1950 he returned to active duty as flight surgeon in the United States Navy and was stationed in Japan. Four months later he met death in the service of his country.

A member of the Duval County Medical Society, Dr. Hardgrave also held membership in the Florida Medical Association, the Arkansas Medical Society and the American Medical Association. He was a member of the Phi Chi medical fraternity and of the American Legion, and was a Thirty-Second Degree Scottish Rite Mason.

Surviving are the widow, Mrs. Betty Hardgrave, and two daughters, Nancy and Mary Ann. His parents, three sisters and two brothers also survive.

Horace Rainsford Drew

Dr. Horace Rainsford Drew of Jacksonville died at his home on May 28, 1951 at the age of 74 years.

Born in Jacksonville on July 6, 1876, Dr. Drew was the son of Horace Drew and Gertrude Fairbanks Drew and the grandson of Columbus Drew, founder of the H. & W. B. Drew Company, and of Major George Rainsford Fairbanks, one of Florida's pioneer historians. After completing his early education in his native city, he attended the University of the South at Sewanee, Tenn., where he received the degree of Doctor of Medicine in 1901.

Returning to Jacksonville, Dr. Drew engaged in the practice of internal medicine and enjoyed a distinguished career for almost half a century. In the Spanish-American War he served with the Jacksonville Light Infantry. In 1916 he was elected to the Associate Staff of St. Luke's Hospital, ten years later became Chief of the Department of Medicine there, and in 1933 was made Chief of Staff. For many years he was prominently identified with Jacksonville activities and was a member of the Seminole Club and the Florida Yacht Club. He was a communicant of St. John's Cathedral. He remained in the active practice of medicine until January 1950.

Dr. Drew was a member of the Duval County Medical Society, of which he was a past president. He was for forty-six years a member of the Florida Medical Association and had for eleven years been a life member. He was also a member of the American Medical Association.

Survivors include the widow, Mrs. Louise Phillips Drew; a son, Horace Rainsford Drew, Jr., of Jacksonville; a brother, Rutledge D. Drew of Island Grove; a granddaughter, Shelley Louise Drew; a grandson, Robert Fairbanks Drew; a half-brother, Hodson Drew; and a half-sister, Mrs. Marguerite Drew Bardin, all of Jacksonville.

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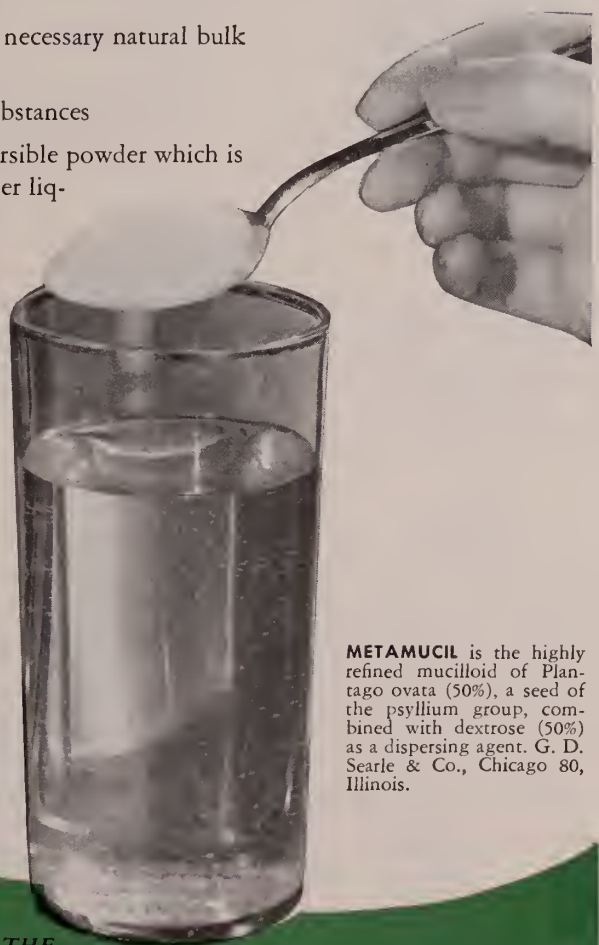
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Joseph Elmer McGunagle

Dr. Joseph Elmer McGunagle of Miami died at his home on June 5, 1951 after an illness of several weeks. He was 65 years of age.

Dr. McGunagle was born in Mt. Clemens, Mich., and received his early education in Detroit. He was awarded the degree of Doctor of Medicine from the Vanderbilt University Medical School in 1912 and engaged in postgraduate work in New York City.

From 1916 to 1919 Dr. McGunagle practiced medicine in Daytona Beach. He then located in Miami, where he continued to practice for thirty years. His specialty was surgery. He was a communicant of SS Peter and Paul Catholic Church.

Dr. McGunagle was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Gertrude McGunagle; a daughter, Mrs. Mary G. Brion; and a son, Joseph A. McGunagle, all of Miami; three brothers, George McGunagle of Mobile, Ala., and Alfred and Art McGunagle of Wyandotte, Mich.

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From where I sit
by Joe Marsh

Hope "Cappy" Told Him Where To Get Off!

"Cappy" Fisher—who just retired after thirty-five years as a railroad conductor—was talking the other day about a salesman who was often one of his passengers.

"That man was so busy," says Cappy, "he used to bring a dictaphone on the train to catch up on his letters. On one trip he'd been rushing around so much he clean forgot to bring his ticket. Left it on his desk."

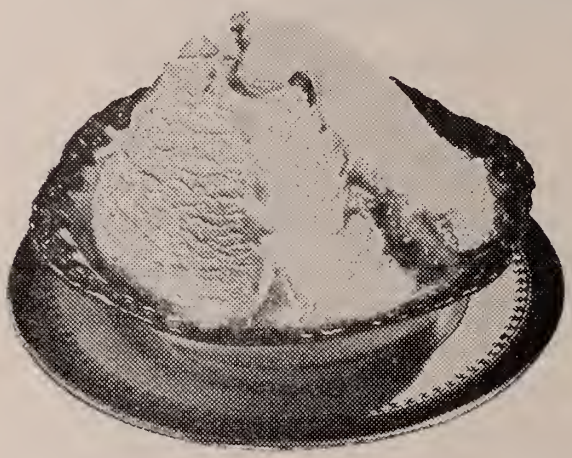
When Cappy started to tell him not to worry about the ticket, the salesman busts out with "Who's worried about the ticket? It's just that now I don't know exactly what city I was going to get off at!"

From where I sit, there *are* people who get so wrapped up in themselves and their ideas they forget "where they're going." Some get so narrow they would tell a man where and how he should practice his profession . . . others would deny their neighbors the right to a glass of beer. Just as trains run on steam and oil, democracies run on freedom!

Joe Marsh

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"When One Hand Washes the Other; Both Can Wash the Face"

Last month, I spoke of the executive turnover of Auxiliary officers on the state and county levels, and of the necessity of keeping in touch during that transition for smooth and continued operation of the organization. For, at each annual state meeting, all counties attend the meeting to report on their achievements; the sum of which constitutes the progress of the state.

This month, all state auxiliaries, including Alaska and Hawaii attended the annual national meeting and the states reported; the sum of which constituted the progress of the Nation in auxiliary activities.

I was proud to report for Florida. Out of thirty six county medical societies we have nineteen auxiliaries with an increase of membership to total 936.

Our program for the past year, self education of the individual and active participation of the auxiliary member in community activities, resulted in better relations and improved communities throughout the state, and was instrumental in achieving the following benefits:

A special series of evening programs at the Woman's Club in Tallahassee, the capitol city, on American citizenship. The history of America was brought up to date by authorities on history, law and economics.

A hookworm survey of a whole community was spearheaded by auxiliary members through a

woman's club and was cited in a national magazine as outstanding.

We have a $1,000 Nurse Scholarship Loan Fund to be used for matching county funds for nurses seeking R. N. specialized training or a Bachelor of Science in nursing at Florida State University.

The philanthropies throughout the state range from a $1,582.99 project for furnishing a premature ward in one group, to a "sunshine committee" which operates to cheer the aged in convalescent homes with personal visits and gifts.

Counties were outstanding in getting "Today's Health," the health magazine of the A.M.A. before the public, and in participating in every health drive and civic need. These and other individual contributions through auxiliary work gave Florida a place of dignity when states reported.

We had seven delegates present out of the nine permitted by our total membership. New York had thirty-eight present. For every one hundred members we have one vote. As our efforts to organize the seventeen remaining counties yield results our voting delegation will increase.

Every new auxiliary represents a new found spring of public relations for the doctor, from which will emanate a refreshing source of good will and creative value to the community.

The membership of the National Auxiliary has reached 57,448. There were four hundred more delegates this year than last.

To be part of this vast organization, whose object is to extend the aims of the medical profession to all organizations which look to the advancement of health and health education, is a privilege.

I will continue to extend a sincere invitation to all doctors' wives to join us in our wholehearted support of Dr. John W. Cline, President of the American Medical Association; and Mrs. Harold Walquist, President of the National Auxiliary in their efforts to preserve freedom in American Medicine.

Mrs. C. Robert DeArmas
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SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting August 20, September 10, September 24, October 8. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting September 10, October 8, November 5. Surgical Anatomy & Clinical Surgery, Two Weeks, starting September 24, October 22, November 19. Basic Principles in General Surgery, Two Weeks, starting September 10. Surgery of Colon & Rectum, One Week, starting September 17, October 15. Esophageal Surgery, One Week, starting October 15. Thoracic Surgery, One Week, starting October 8. Gallbladder Surgery, Ten Hours, starting October 22. Breast & Thyroid Surgery, One Week, starting October 1. Fractures & Traumatic Surgery, Two Weeks, starting October 8.

GYNECOLOGY—Intensive Course, Two Weeks, starting September 24, October 22. Vaginal Approach to Pelvic Surgery, One Week, starting September 17, November 5.

OBSTETRICS—Intensive Course, Two Weeks, starting September 10, November 5.

MEDICINE—Intensive General Course, Two Weeks, starting October 1. Gastroenterology, Two Weeks, starting October 15. Electrocardiography & Heart Disease, Two Weeks, starting October 22.

UROLOGY—Intensive Course, Two Weeks, starting September 24.

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BOOKS RECEIVED

MASTER YOUR MIND. By Samuel Kahn, M.D., Ph.D. Pp. 262. New York, Rockport Press, Inc., 1951.

This book is written to appeal to "students, teachers, businessmen, parents, social workers and other intelligent people who are interested in mental efficiency engineering, both for themselves and for guiding others."

Formerly Clinical Professor of Neurology and Psychiatry at Georgetown and George Washington Universities, and now of the Department of Psychology and Psychiatry of Long Island University, Dr. Kahn draws upon wide experience in teaching and in handling and guiding many normal and abnormal people to make this book practical and helpful to those genuinely interested in helping themselves and others to be successful. Among the subjects he discusses are the understanding of the conscious and unconscious mind, the principles of child guidance and dynamic psychology, the economy and hygiene of learning, memory methods, study habits, health practices, causes of success and failure, the building of personality and character, attitudes and efficient habits and activities. For more serious students, there are chapters which deal with note taking, library methods, bibliographic methods, and mental and psychologic philosophies.



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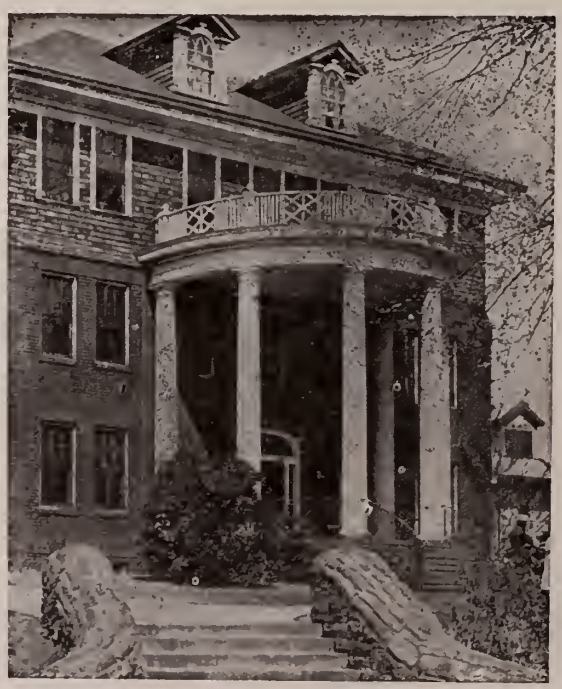
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1. Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.
2. Berberian, D. A., Dennis, E. W., and Pipkin, C. A.: *Am. Jour. Trop. Med.*, 30:613, Sept., 1950.

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
a Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '52
a Medical Districts	William C. Roberts, Panama City	Council Chairman	
orthwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Pensacola, Oct. 22, '51
ortheast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Orlando, Oct. 26, '51
outhwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	B'denton-Sarasota, Oct 24, '51
outheast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Vero Beach, Oct. 25, '51
a Specialty Societies			
ny of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	Hollywood, Apr. 27, '52
Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	" "
esiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
r, Am. Coll. Chest Phys	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	" "
rial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	" "
ogy & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
d Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
l & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	" "
edic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	" "
gical Society	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Laudardale	" "
ic Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	Orlando, Nov. 10-11, '51
ogic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	Hollywood, Apr. 27, '52
gical Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
ical Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
—			
Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 10, '51
d Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando, Dec. 2, '51
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 27, '52
al Society, State	John I. Todd, D.D.S., Jacksonville	Tom Price, D.D.S., Miami	Jacksonville, Apr. 20-23, '52
ital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando, Dec. 3-4, '51
cal Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	Jacksonville, Nov. 25-27, '51
cal Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
es Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
maceutical Association, State	Mr. Euless Watford, Chipley	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-21, '52
ic Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
rculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Pt. St. Joe	
an's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	Hollywood, Apr. 27-29, '52
an Medical Association	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	
A. Clinical Session	Elmer L. Henderson, Louisville, Ky.	Geo. F. Lull, Chicago	Los Angeles, Dec. 4-7, '51
rn Medical Association	Curtice Rosser, Dallas, Texas	Mr. C. P. Loranz, Birmingham	Dallas, Texas, Nov. 5-8, '51
a Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19, '52
, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 11-14, '52
Hospital Conference	Edwin B. Peel, Atlanta	Mr. R. G. Ramsey, Jr., Memphis	Atlanta, Apr. 16-18, '52
astern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath, B, MacInnis, Columbia, S.C.	Augusta, Ga., Mar. 21-22, '52
astern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	Boca Raton, Apr. 2-5, '52
astern Surgical Congress	Joseph S. Stewart, Miami	B. T. Beasley, Atlanta	Atlanta, Mar. 10-13, '52
oast Clinical Society	Wesley Lake, Pass Christian, Miss.	C. D. Taylor, Pass Christian, Miss.	Gulfport, Miss., October, '51

MEDICAL DISTRICT MEETINGS

The Chairman of the Council, Dr. William C. Roberts, has announced that the dates of the Four Medical District meetings have been officially set by the Council.

Every member of the Association is urged to attend the meeting in his district and any of the other three meetings as desired.

Pensacola, Oct. 22, 1951

Bradenton-Sarasota, Oct. 24, 1951

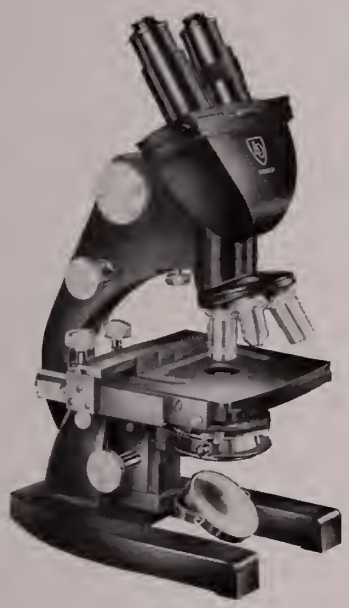
Vero Beach, Oct. 25, 1951

Orlando, Oct. 26, 1951

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Total	MEMBERS Paid	COUNCILOR
A	Bay	James M. Nixon, M.D. 825 Jenks Ave. Panama City	Harold E. Wager, M.D. Box 984 Panama City		21	100%	A-1-52 Arthur J. Butt, M.D. Pensacola
	Escambia *Santa Rosa*	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	74	67	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	7	100%	
	Jackson-Calhoun	Jasper B. Dowling, M.D. Route 1 Altha	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	15	
	Walton-Okaloosa	Arthur G. Williams, Jr., M.D. Valparaiso	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker-Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	14	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	John T. Benbow, M.D. Chattahoochee	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	Quarterly 7:30 P.M.	52	49	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Suwannee	John N. Sims, Sr., M.D. Suwannee St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	7	
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		3	100%	
	Taylor *Dixie-Lafayette*	Ralph J. Greene, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	223
B	Alachua *Bradford, Gilchrist, Union*	James M. McClamroch, M.D. 903 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 819 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	47	100%	
	Duval *Clay*	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	243	228	
	Marion *Levy*	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	29	26	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	100%	
	Putnam	Claude M. Knight, M.D. 121 Madison St. Palatka	James W. Brantley, M.D. Grandin	2nd Tuesday 6:00 P.M.	11	100%	
	St. Johns	Joseph A. Shelley, M.D. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	16	14	
	Brevard	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	20	19	
	Lake *Sumter*	H. Durham Young, Jr., M.D. 411 Lakeshore Dr. Leesburg	Lawton F. Douglass, M.D. Umatilla	1st Wednesday 7:30 P.M.	26	24	
	Orange *Osceola*	Fred Mathers, M.D. 314 American Bldg. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	149	100%	B-4-53 Eugene L. Jewett, M.D. Orlando
	Seminole	Thomas F. McDaniel, M.D. 315 Magnolia Ave. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	13	100%	
	Volusia *Flagler*	Peter A. Drohomer, M.D. 210 Volusia Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	74	71	638
C	Hillsborough	R. Renfro Duke, M.D. 708 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	162	154	
	Manatee	Roderic O. Jones, M.D. 430 10th St., W. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	3rd Tuesday 7:00 P.M.	21	19	
	Pasco-Hernando-Citrus	Gail M. Osterhout, M.D. Box 296 Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	13	100%	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	Claude B. Wright, M.D. 214 First Fed. Bldg. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	183	181	
	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 203 Van Skike Bldg. Sarasota	2nd Tuesday 8:30 P.M.	42	41	
	DeSoto-Hardee-Highlands-Glades	Hubert W. Coleman, M.D. Box 98 Avon Park	Stanley K. Wallace, M.D. Sebring	2nd Tuesday 8:00 P.M.	26	24	
	Lee-Charlotte-Collier-Hendry	William H. Grace, M.D. 1925 McGregor Blvd. Ft. Myers	Angus D. Grace, M.D. 308 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	24	23	C-6-52 Leldon W. Martin, M.D. Sebring
	Polk	John W. Vaughn, M.D. Box 475 Lakeland	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	86	81	557
D	Indian River	Erasmus B. Hardee, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	
	Palm Beach	R. M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	Lorenzo James, M.D. 1300 N. Dixie Ave. West Palm Beach	3rd Monday 8:00 P.M.	103	95	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	St. Lucie-Okeechobee-Martin	Julian D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	16	14	
	Broward	M. Austin Loveioy, M.D. 409 Blount Bldg. Ft. Lauderdale	Thomas L. Roberts, Jr., M.D. 408 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	80	78	
	Dade	Jack O. Cleveland, M.D. 167 Alcazar Ave. Coral Gables	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	576	517	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	Ralph Herz, M.D. 420 Simonton St. Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	10	100%	792

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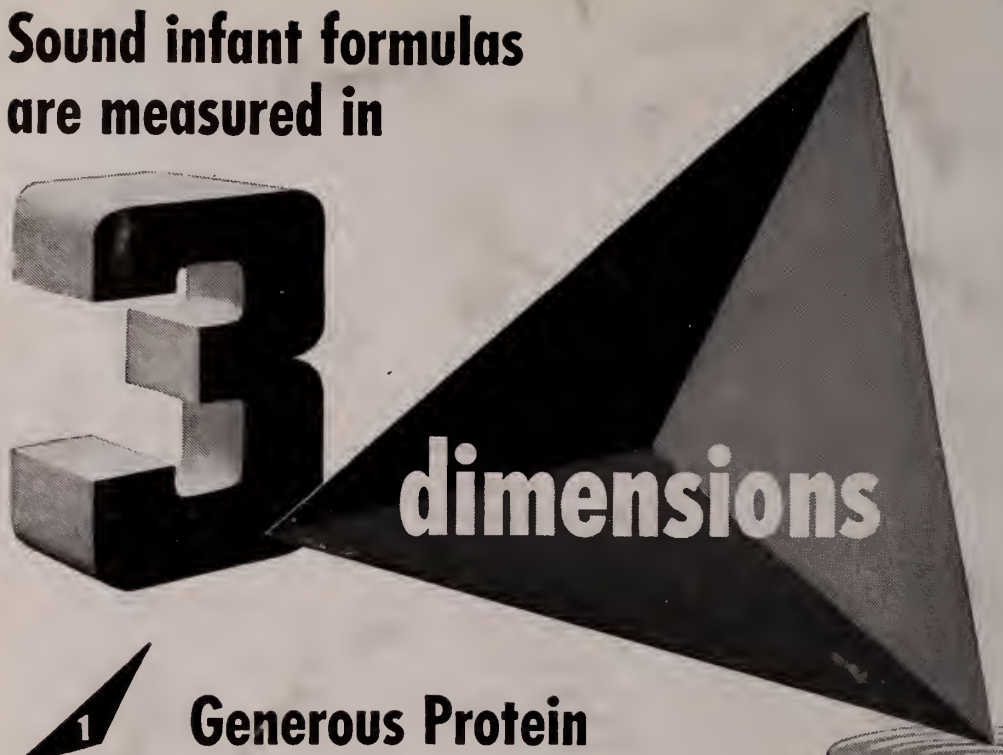
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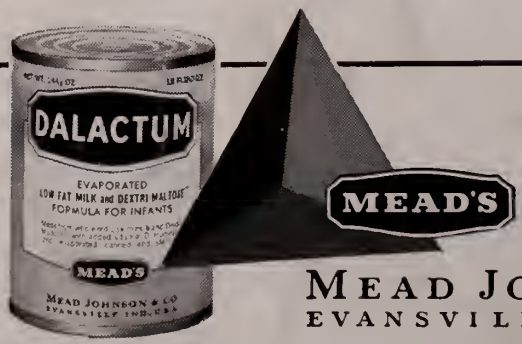
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Vol. XXXVIII SEPTEMBER, 1951 No. 3

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Volume XXXVIII SEPTEMBER, 1951 No. 3

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917: authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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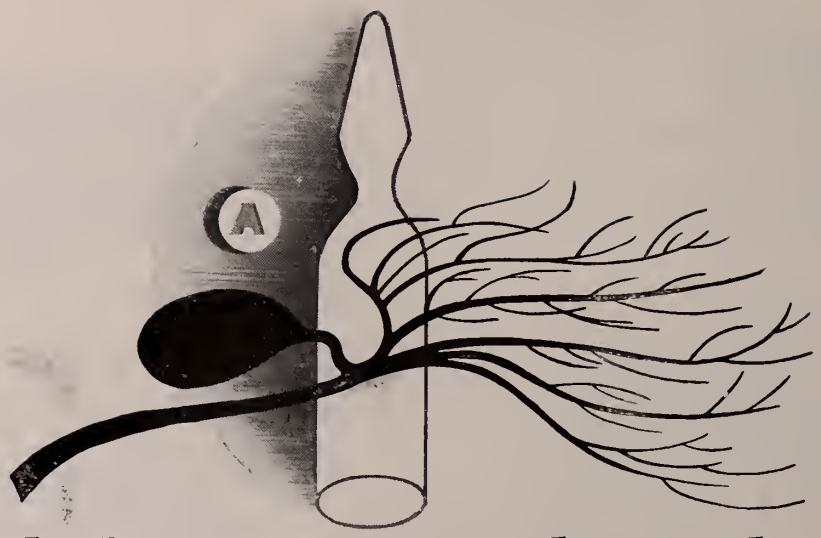
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*McLester, J. S.: Protein Comes Into Its Own, J.A.M.A. *139*:897 (Apr. 2,) 1949

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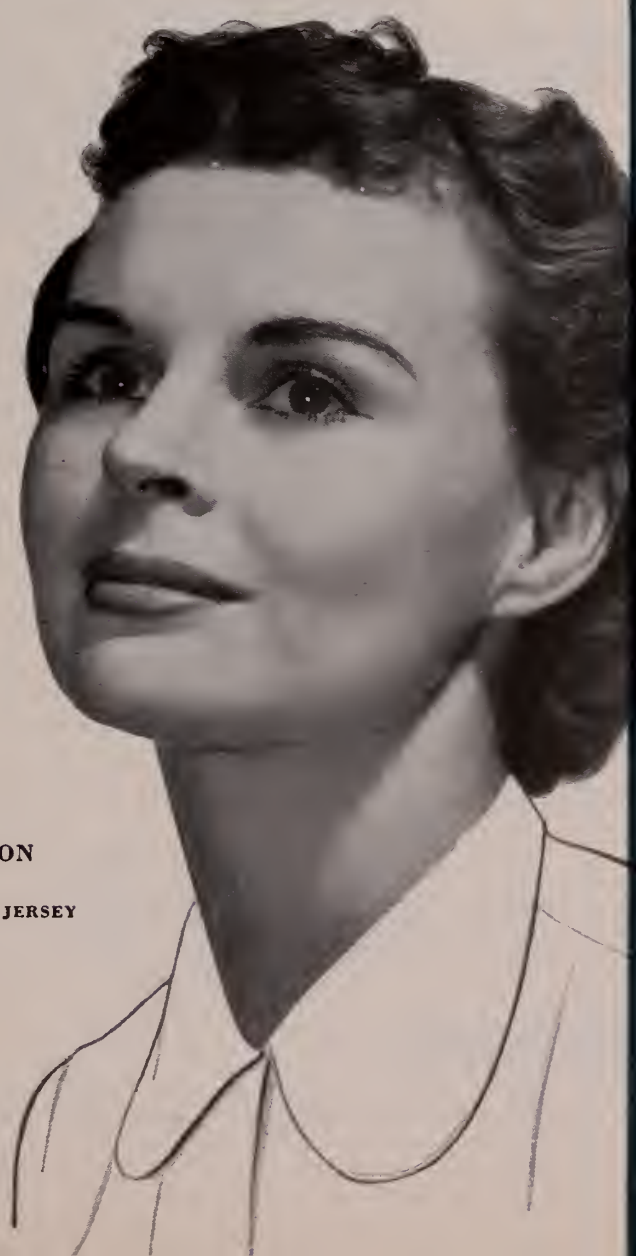
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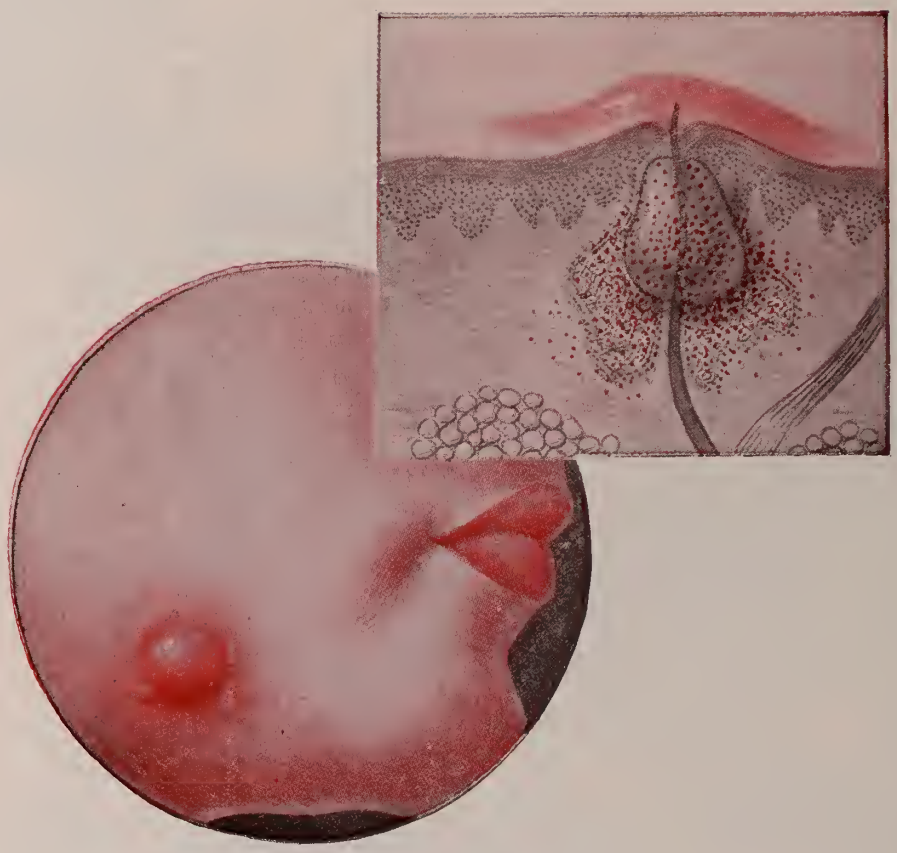
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Wright, L. T., et al.: Antibiotics and Chemotherapy 1:165 (June) 1951.

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Furunculosis • Impetigo
Infections secondary to Acne vulgaris
Erysipelas • Peritonitis

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Friedländer's pneumonia
Mixed bacterial pneumonias
Pertussis • Diffuse bronchopneumonia
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Respiratory tract infections
Cellulitis • Peritonitis • Tularemia

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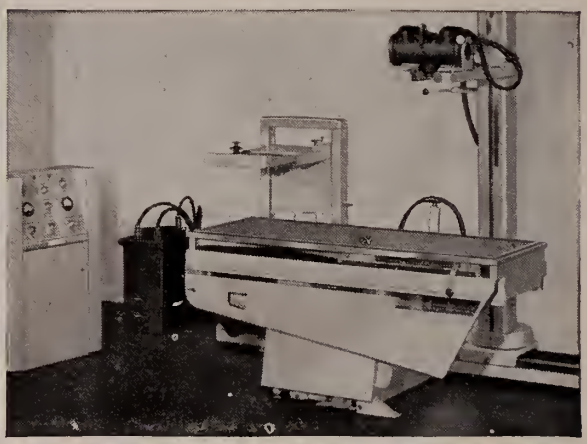
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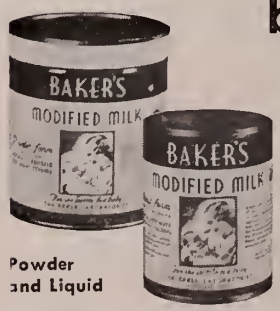
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXVIII Jacksonville, Florida, September, 1951 No. 3

Endocrine Relationships in Diabetes Mellitus and Carbohydrate Metabolism

SIDNEY DAVIDSON, M.D.
LAKE WORTH

The role of the endocrines in the metabolism of carbohydrates and in diabetes mellitus is of fundamental importance and has received a great deal of attention, both clinically and experimentally, for the last sixty years. The earliest experimental evidence of these relationships was the work of von Mering and Minkowski,[1] who first discovered that removal of the pancreas in dogs resulted in diabetes mellitus. Hedon[2] demonstrated that diabetes was prevented if a piece of pancreas was transplanted to another part of the body of a depancreatized animal. The hormonal nature of this pancreatic factor was proved by Banting and Best,[3] who prepared a potent nontoxic extract of the pancreas which alleviated the diabetes of depancreatized dogs and of hospital patients.

It was obvious, then, that insulin was produced by the pancreas, and there is as yet no evidence that there is any extrapancreatic source. The pancreatic source has been shown to be the islets of Langerhans, the beta cells of which appear to be the essential endocrine structure. Diabetes, therefore, results from a deficiency of a particular hormone, insulin, manufactured by the beta cells of the islets of Langerhans.

Diabetes Mellitus

For a while it appeared that the pancreas alone was implicated in diabetes, but Houssay and Magenta[4] then showed that the pituitary also is involved. They demonstrated great insulin sensitivity in the hypophysectomized animal. It was shown[5] that hypophysectomy greatly prolonged the survival of the completely depancreatized animal. The diabetes could always be reinvoked by the administration of hypophyseal extracts.

Diabetes has been experimentally produced by injections of extracts of the anterior pituitary.[6,7] In the adult dog, such pituitary diabetes can be divided into two phases: a transient diabetes present during the injections of the extracts; and a permanent diabetes after cessation of the injections. The diabetes resulting from the administration of anterior pituitary extracts may be severe, with high fasting blood sugar values, glycosuria, increased ketone body formation, increased nitrogen excretion, and other changes characteristic of diabetes.

The injection of these anterior pituitary extracts results in certain changes in the pancreas. The insulin content of the pancreas is greatly reduced, and there are extensive changes in the islets of Langerhans.[8,9] These changes are predominantly in the beta cells, which show progressive degenerative changes. If the effect of the injections is not complete, the islet cells can be restored and come back to normal after the injections are discontinued. If the extract is more potent, or the period of administration longer, the islets may be permanently damaged, and a permanent reduction of normally functioning beta cells will result. When these extracts are first given, the diabetes is a pituitary diabetes (hypophyseal diabetes). Later, the persistence of the diabetes is dependent on permanent pancreatic changes, and the diabetes is then a pancreatic diabetes (metahypophyseal).

There is a difference between the diabetes obtained by pancreatectomy and that obtained through use of the anterior pituitary extracts.[10] The predominant effect of the hormones present in the anterior pituitary extracts consists in the destruction of the beta cells; so it would appear that the diabetes results from destruction of the

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 24, 1951.

beta cells and is similar to the diabetes resulting from the use of alloxan and from depancreatization. This, however, is not true. Houssay and his associates[6] have shown that the grafted pancreas does not reduce the hyperglycemia of the pituitary diabetic as readily as it does that of the depancreatized diabetic. The dog with pituitary diabetes shows a greater resistance to administered insulin than does the pancreatectomized animal. There is, therefore, an extrapancreatic diabetic effect of the hypophyseal extracts.

The adrenals have also been shown to be of great importance in the genesis of experimental diabetes. The removal of the adrenals ameliorates the diabetes resulting from pancreatectomy.[11] Adrenal cortical substances cause temporary hyperglycemia and glycosuria when administered to the normal rat.[12] A temporary diabetes resistant to insulin has been induced in man by the administration of purified preparations of ACTH.[13]

Some of the diabetogenic effect of the anterior pituitary is mediated through the adrenal via ACTH. It is, however, not the sole diabetogenic agent of the pituitary. Pure growth hormone[10] alone is diabetogenic. The destruction of the beta cells following administration of anterior pituitary extracts is a result of overstimulation and exhaustion following the production of hyperglycemia by ACTH and growth hormone.

Dohan and Lukens[14] demonstrated that hyperglycemia will produce the diabetic state by causing degeneration of the beta cells, by the administration of huge amounts of glucose. The hyperglycemia produced by anterior pituitary hormones, however, is not the sole mechanism for the production of metahypophyseal diabetes. Growth hormone, in addition to its effect on the beta cells by the production of hyperglycemia, also causes direct stimulation of the islets, exhaustion, and then degeneration in its role as a somatotropin.

Estrogens have been known to be diabetogenic in animals whose caloric intake has been maintained by forced feeding.[15] Clinically, however, there is evidence to show that diabetics may require less insulin while under female hormone therapy.

Thyroid administration per se may produce diabetes, although this effect is produced only when a large part of the pancreas is removed.[16]

Certain endocrines, namely the cortical hormones, are more significantly involved in experimental diabetes than others. Long and Lukens[17] showed that adrenalectomy alleviates pancreatectomy much as hypophysectomy does. Cortical hormones have been shown to restore the diabetes of the adrenalectomized depancreatized animal and to be capable of increasing concentrations of blood sugar in intact animals, causing hyperglycemia and glycosuria.[18]

Carbohydrate Metabolism

Not all corticosteroids are capable of influencing carbohydrate metabolism. The ability to affect carbohydrate metabolism is a function of the chemical structure.[19] Those compounds which are oxygenated at carbon atoms 11 and 16, such as Compound E (cortisone) and Compound F (17-hydroxycorticosterone), have greater carbohydrate activity than Compound A (11-dehydrocorticosterone), while 11-desoxycorticosterone, which has no oxygen atom at either carbon 11 or 17, has no carbohydrate activity (fig. 1).

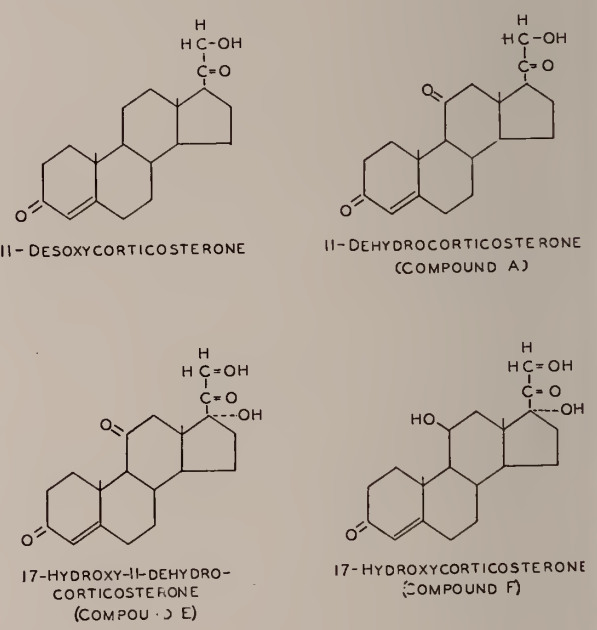


Fig. 1 — Four steroid hormones of the adrenal cortex. The presence of oxygen atoms on carbons 11 and 17, as in compound E (17-hydroxy-11-dehydrocorticosterone) and compound F, (17-hydroxycorticosterone), is associated with the greatest degree of carbohydrate activity.

The diabetic state has been induced not only in animals, but in humans as well. Administration of ACTH[13] has been shown to produce, in normal humans, glycosuria, increased levels of fasting blood sugar, and glucose tolerance curves typical of the diabetic state. This diabetic state is characterized by great resistance to the action of insulin, but is of mild character in the fasting state.

The experimental role of the corticosteroids in carbohydrate metabolism has considerable clinical confirmation.[19] Careful studies of steroid metabolism in Addison's disease, Addison's disease with diabetes mellitus, and hyperfunctioning lesions of the adrenal cortex, have confirmed the experimental findings.

In studies on patients[19] with Cushing's syndrome associated with tumor or hyperplasia of the adrenal cortex, all were found to have diminished carbohydrate tolerance. In patients with Cushing's syndrome, excessive amounts of cortisone and Compound F have been obtained from the urine. These compounds are undoubtedly responsible for the diabetic-like state in this syndrome. It has also been possible to induce many of the features of Cushing's syndrome, including typical diabetic glucose tolerance curves, by the administration of Compound E (cortisone). When the administration of the cortisone is stopped, the glucose tolerance curve becomes normal.

It has been mentioned that, in some cases of Cushing's syndrome, large amounts of cortical steroids have been obtained from the urine. Mason and Sprague[19] reported a case of typical Cushing's syndrome in a boy. He had diabetes which was typical of steroid diabetes, insulin insensitivity which was mild in character during fasting, and negative nitrogen balance. In this case, the urinary excretion of corticosteroids was twenty times the normal amount, and enough Compound E was isolated to account for at least half.

In Addison's disease, the hypoglycemia is alleviated by the administration of either cortisone or Compound A; while in patients with diabetes and Addison's disease, cortisone causes a definite and severe intensification of the diabetic state.[19]

Although in most cases of diabetes mellitus, the disturbed metabolism is explainable on the basis of a deficiency of insulin, in some few cases there is clear evidence of disturbance of function of other glands of internal secretion. Despite all the evidence of the influence of most of the endocrines on carbohydrate metabolism, in the majority of cases the functions of the anterior pituitary, the thyroid, and the adrenal cortex are normal by all clinically available methods of measurement. There is an occasional case, however, in which hyperfunction of the anterior pituitary, the thyroid, or the adrenal cortex may contribute to the development or to the intensification of the already present diabetes.

The converse is also known clinically. Hypofunction of the anterior pituitary or the adrenal cortex resulting from destructive lesions or surgical extirpation may ameliorate existing diabetes to varying degrees.[20]

Diabetes in hyperthyroidism may disappear when the normal function of the thyroid is restored. Cases of this type are sometimes regarded as examples of latent diabetes brought to light by the metabolic stress and strain of hyperthyroidism.[16]

Hyperfunctioning lesions of the anterior pituitary, such as acromegaly, are not always associated with a diabetic state. The incidence is, however, greater than that which would be expected by chance. It is possible that, in a similar manner to diabetic states in hyperthyroidism, a fundamental deficiency of the islands must exist before a hyperfunctioning lesion of the anterior pituitary can produce diabetes.

The diabetes in acromegaly[16] is mild and relatively insensitive to insulin. When the lesion of the pituitary becomes inactive, either spontaneously or as a result of treatment, the diabetes may become mild or vanish.

Hyperthyroidism in a nondiabetic may produce glucose tolerance curves resembling those of patients with mild diabetes mellitus, either because of an increased rate of absorption of glucose from the gastrointestinal tract, or impairment of the function of the liver to store glucose as glycogen. When hyperthyroidism develops in a person with diabetes, the decreased sugar tolerance already existing is further depressed, and the diabetes may become more severe. Diabetes may first become manifest with the onset of hyperthyroidism; the symptoms may be attributed to the uncontrolled diabetes, and the diagnosis of hyperthyroidism overlooked.

Myxedema produces effects in diabetic patients opposite to those observed in hyperthyroidism. That is, the diabetes may be ameliorated to some degree, but the changes are not usually striking. Myxedema in nondiabetic patients may produce an increased tolerance to glucose administered orally.

The relationship of the diabetic state to clinical hypofunction or hyperfunction of the adrenals is similar to its relationship to dysfunction of the anterior pituitary and of the thyroid. Hypofunction of the adrenal gland ameliorates a previously

existing diabetic state, while hypoglycemia is a well known common part of the clinical picture of Addison's disease.

In the discussion of the relationship of the various endocrines to the diabetic state, it should be noted that, although hyperfunctioning lesions of the adrenals and, in fact, certain of the adrenal hormones themselves, can produce a diabetic state,[19] this steroid diabetes differs in many ways from the types of clinical diabetes usually encountered. While it is not at all probable that the cortical hormones play a role in diabetes as one commonly sees it, nevertheless they may play a role in the initiation of the diabetic state.

Conclusion

Although diabetes is due primarily to a disturbance in carbohydrate metabolism which has its genesis in a pancreatic insufficiency, disturbances of the other endocrine glands may modify the diabetic state both experimentally and clinically. In the usual clinical diabetes, however, there is no evidence that any endocrine gland other than the pancreas is involved.

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8 South J Street.

MEDICAL DISTRICT MEETINGS

The Chairman of the Council, Dr. William C. Roberts, has announced that the dates of the Four Medical District meetings have been officially set by the Council.

Every member of the Association is urged to attend the meeting in his district and any of the other three meetings as desired.

Pensacola, Oct. 22, 1951

Bradenton-Sarasota, Oct. 24, 1951

Vero Beach, Oct. 25, 1951

Orlando, Oct. 26, 1951

A Survey of Progress in the General Field of Health in Florida for the Period from 1940 to 1949

Wilson T. Sowder, M.D.
Jacksonville

Any physician and many lay people could easily present interesting evidence of progress in the general field of health in Florida during the period from 1940 to 1949. We are fortunate at the State Board of Health, however, in having available rather complete and accurate figures illustrating this progress, and it was for this reason that the Committee on Scientific Work of the Florida Medical Association allowed me to present this subject.

Because the members of the Association are all familar, in a general way, with the tremendous progress we have made, I shall limit the narrative portion of my discussion to brief comments on the tables and charts that I am showing:

Table 1 may be of special interest in that it shows the increase in our white population to be far greater than that of our Negro population during the decade. This fact should be considered when we congratulate ourselves upon our lower death rates since it is a well known fact that the death rate among Negroes is much greater than among whites.

Our birth rate (chart 1) increased at a rather steady rate throughout the decade, as it did throughout the country.

Table 2 gives the most significant evidence of progress. The decline of the death rate from 11.2 to 9.5 per 1,000 is an improvement of 15 per cent (chart 2). The significance of these figures may be better understood by considering the fact that had this improvement not come about, 4,486 more people would have died in 1949 than did so. Instead of having 25,317 deaths in 1949, we would have had 29,803; and for every six persons dying in 1949, one additional person would have died. Looking at the matter from another point of view, we can also say that 3,264 lives might have been saved in 1940 had we been so fortunate as to have had the health and medical resources that we had in 1949. Not shown in the table is the fact that the death rate for Negroes decreased more than that for whites, dropping 18 per cent as compared to 10 per cent for whites. The death rate for Negroes, however, remained 37 per cent higher than that for whites at the end of the decade.

Our infant death rate (table 3) showed a 37 per cent decrease (chart 3), which is most gratifying, but our pride in this accomplishment should be restrained by the fact that we still rank near the bottom in comparison with other states in this category.

The same statement may be made about our maternal death rate (table 4), which declined by 72 per cent (chart 4). Here the percentage difference between our death rate and that of the United States as a whole is much greater than in the case of our infant death rate. You will be glad to know, however, that in 1950 our maternal death

ESTIMATED MID-YEAR POPULATION OF FLORIDA, BY COLOR, 1940 AND 1949

YEAR	TOTAL	WHITE	COLORED
1940	1,915,155	1,397,748	517,407
1949	2,661,000	2,076,000	585,000
PER CENT INCREASE	38.9	48.5	13.1

Table 1

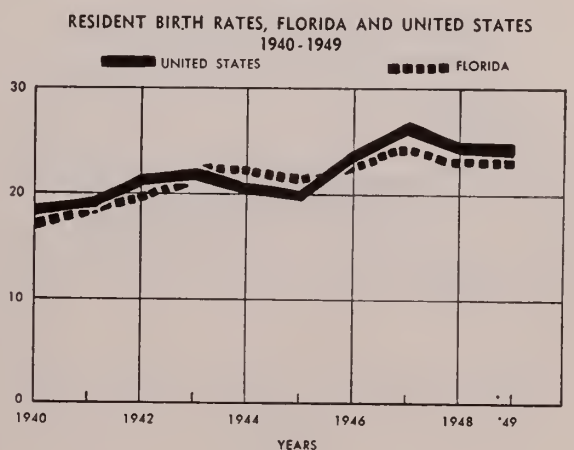


Chart 1

State Health Officer, Florida State Board of Health.
Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 25, 1951.

rate took another substantial drop down to 1.4 deaths per 1,000 live births.

One of the chief reasons for this improvement is perhaps illustrated by the figures shown in table 5 indicating that physicians were in attendance in a greater percentage of births. Our figures are incomplete for the entire decade, but what we have show that the percentage of births occurring in hospitals is increasing. Naturally, the discovery of new drugs, antibiotics, and other advances in medical knowledge have also contributed to the decline in these death rates.

The tuberculosis death rate (table 6) declined 50 per cent (chart 5) and the death rate from syphilis (table 7) to an even greater extent (chart 6). We at the State Board of Health, of course, feel that the intensive campaign we have carried on against these diseases during the last ten years has had its effect.

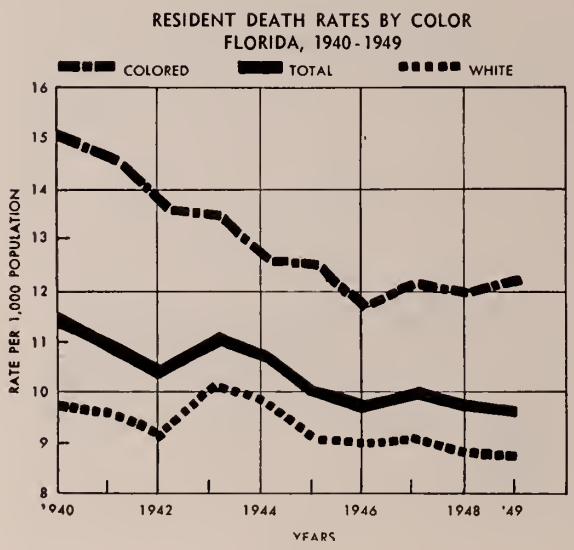


Chart 2

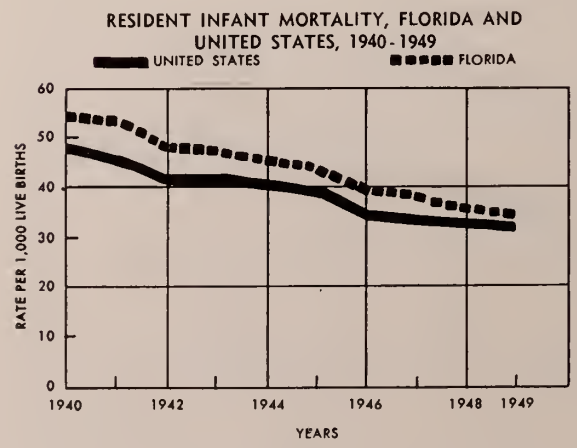


Chart 3

Nothing can be said definitely about any trend in the incidence or the death rate in the case of poliomyelitis (chart 7). As you all know, this is still one of our major unsolved medical and health problems.

The death rates from cancer (chart 8) and heart disease (chart 9) were substantially lower here than in the remainder of the United States, but show a steady increase over the years. This is generally ascribed to the fact that people are

RESIDENT BIRTHS AND DEATHS WITH RATES PER 1,000 POPULATION FLORIDA 1940-1949

YEAR	BIRTHS	RATE	DEATHS	RATE
1949	61,642	23.2	25,317	9.5
1948	59,685	23.3	24,505	9.6
1947	60,201	24.4	24,150	9.8
1946	54,347	22.9	22,750	9.6
1945	48,839	21.5	22,594	9.9
1944	49,186	22.4	23,251	10.6
1943	46,763	22.0	23,213	10.9
1942	40,675	19.8	21,144	10.3
1941	37,351	18.8	21,438	10.8
1940	33,696	17.6	21,458	11.2

Table 2

RESIDENT INFANT MORTALITY RATES PER 1,000 LIVE BIRTHS, BY COLOR, FLORIDA, 1940-1949

YEAR	TOTAL	WHITE	COLORED
1949	33.7	27.4	50.1
1948	34.9	30.9	45.6
1947	37.8	33.8	49.5
1946	38.5	33.6	53.2
1945	42.8	36.3	61.6
1944	44.9	37.8	66.0
1943	46.3	38.5	68.6
1942	47.5	38.6	70.6
1941	52.6	44.1	73.8
1940	53.8	44.2	76.8

NOTE: U. S. PROVISIONAL RATE FOR 1949 WAS 31.8

Table 3

RESIDENT MATERNAL DEATH RATES PER 1,000 LIVE BIRTHS BY COLOR, FLORIDA 1940-1949

YEAR	TOTAL	WHITE	COLORED
1949	1.8	1.0	3.6
1948	1.9	1.1	4.2
1947	2.2	1.3	5.0
1946	2.9	1.9	5.9
1945	2.9	1.8	6.0
1944	3.3	2.3	6.0
1943	3.5	2.7	6.1
1942	4.0	2.5	8.0
1941	6.1	4.5	10.0
1940	6.4	5.0	9.8

NOTE: U. S. PROVISIONAL RATE FOR 1949 WAS 1.0

Table 4

living longer and surviving in greater numbers to the ages when these diseases are more prevalent. Better diagnosis is also considered to be a factor. It is an interesting fact that the combined death rate from cardio-vascular-renal diseases did not increase, so that it may be that some of the increase in heart disease is due to changing fashions in diagnosis.

PERCENTAGE OF RESIDENT BIRTHS ATTENDED BY PHYSICIANS (M.D.), BY COLOR, FLORIDA 1940 AND 1949

	1940	1949
WHITE	91 %	96 %
COLORED	28	48
TOTAL	73	83

Table 5

RESIDENT TUBERCULOSIS (ALL FORMS) DEATHS AND DEATH RATES PER 100,000 POPULATION, FLORIDA, 1940-1949

YEAR	DEATHS	RATES
1949	677	25.4
1948	733	28.6
1947	796	32.3
1946	701	29.6
1945	708	31.2
1944	789	35.9
1943	842	39.6
1942	867	42.2
1941	927	46.7
1940	973	50.8

NOTE: PROVISIONAL U. S. RATE FOR 1949 WAS 26.2
NOTE: PROVISIONAL FIGURES FLORIDA 1950:
DEATHS 528 RATE 19.1

Table 6

RESIDENT SYPHILIS DEATHS AND DEATH RATES* PER 100,000 POPULATION, FLORIDA, 1940-1949

YEAR	DEATHS	RATES
1949	198	7.4
1948	176	7.1
1947	184	7.6
1946	199	8.5
1945	213	9.4
1944	256	11.7
1943	287	13.5
1942	269	13.1
1941	359	18.1
1940	320	16.9

NOTE: PROVISIONAL U.S.RATE FOR 1949 WAS 5.5
NOTE: PROVISIONAL FIGURES FLORIDA 1950:
DEATHS 179 RATE 6.5
* DEATHS AND RATES PRIOR TO 1949 ADJUSTED FOR CAUSE OF DEATH CODING CHANGES

Table 7

While it is not the purpose of this paper to discuss the reasons for the improvement in health during the decade, I thought it well to give you some facts on our health facilities and personnel. Table 8 shows the number and percentage increase in various types of practitioners in the state. It is believed that the large increase in the number of registered nurses was more apparent than real, and was due to more complete registration. The progress shown cannot be ascribed to an increase in the number of practitioners in the healing arts because these did not increase much more proportionately than did our population.

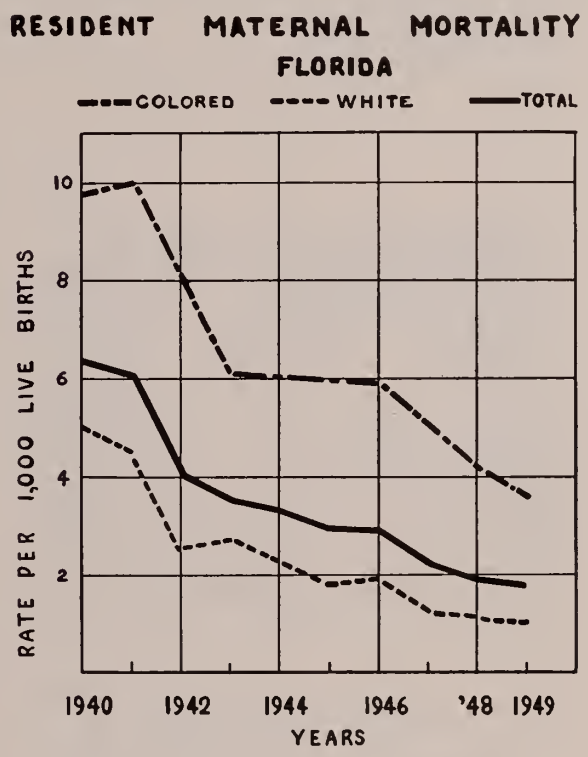


Chart 4

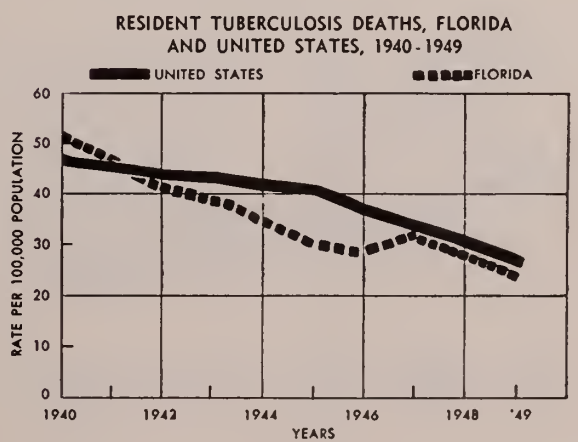


Chart 5

PHYSICIANS AND OTHERS IN HEALTH PROFESSIONS FLORIDA 1940-1949

	1940	1949	PER CENT INCREASE
MEDICAL DOCTORS (M.D.) REGISTERED	2418	3512	45.2
OSTEOPATHS (D.O.) REGISTERED	492	426	-13.4
CHIROPRACTORS (D.C.) REGISTERED	221	387	75.1
NATUROPATHS (N.D.) REGISTERED	230	236	2.6
DENTISTS	845	1302	54.1
NURSES, REGISTERED	5518	13,420	143.2
MEDICAL DOCTORS (M.D.) REGISTERED AND RESIDING IN FLORIDA	1985	2823	42.2

Table 8

COMPARISON OF HOSPITAL FACILITIES BY TYPE SERVICE RENDERED, FLORIDA, 1940 AND 1949
(EXCLUDING HOSPITALS CONTROLLED BY FEDERAL GOVERNMENT)

TYPE SERVICE RENDERED	HOSPITALS 1940	HOSPITALS 1949	BEDS 1940	BEDS 1949
GENERAL	75	102	5183	7469
NERVOUS AND MENTAL	5	6	5536	7737
TUBERCULOSIS	6	4	595	1139
OTHER SPECIAL	10	16	531	979
TOTAL	96	128	11845	17324

SOURCE: J. A. M. A.

Table 10

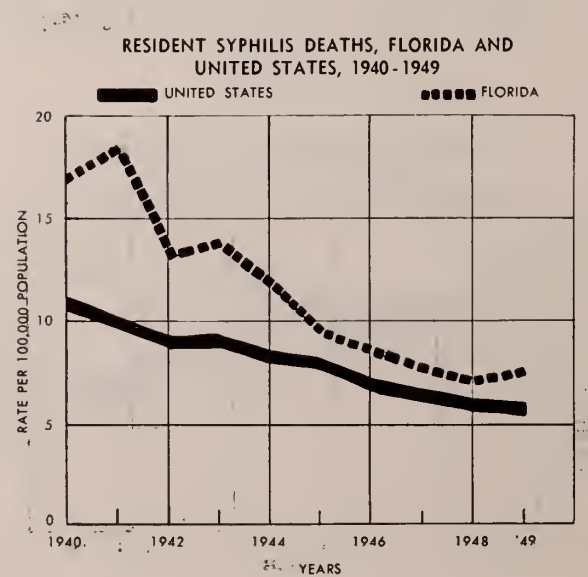


Chart 6

COMPARISON OF HOSPITAL FACILITIES BY TYPE OF CONTROL, FLORIDA, 1940 AND 1949
(EXCLUDING HOSPITALS CONTROLLED BY FEDERAL GOVERNMENT)

TYPE OF CONTROL	BEDS 1940	BEDS 1949	BASSINETS 1940	BASSINETS 1949
STATE	5966	9039	7	44
LOCAL GOVERNMENT	2495	2931	218	483
NON-GOVERNMENT	3384	5354	520	1088
TOTAL	11845	17324	745	1615

SOURCE: J. A. M. A.

Table 9

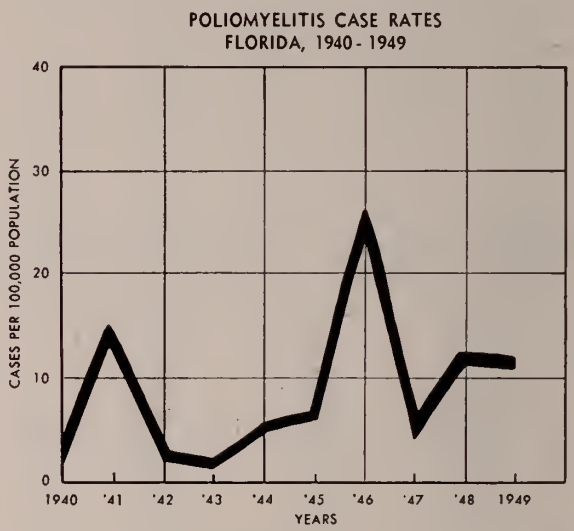


Chart 7

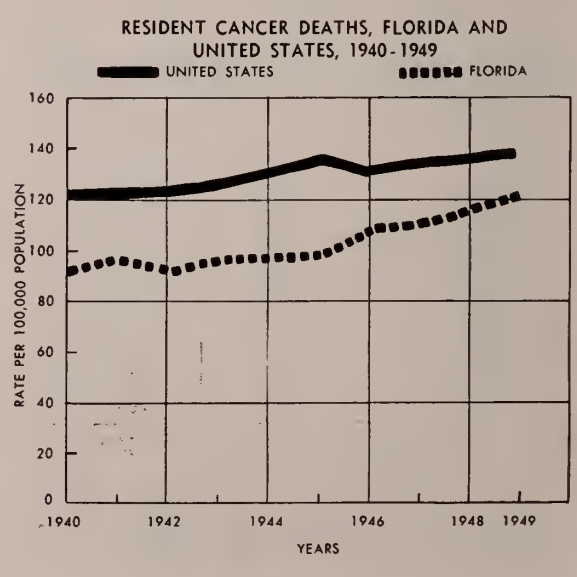


Chart 8

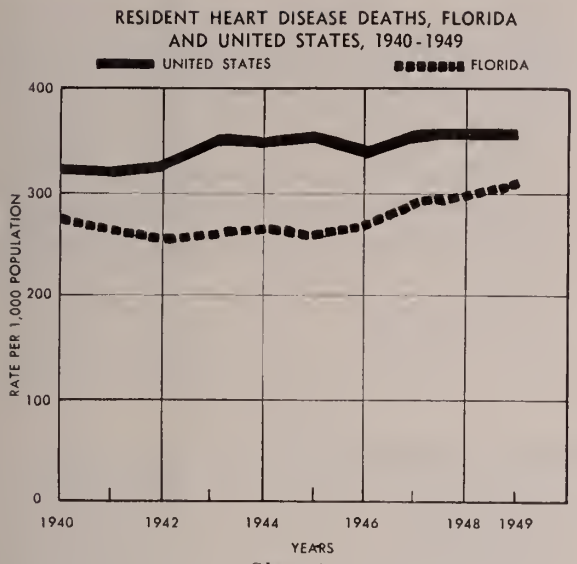


Chart 9

Table 9 shows the increase in hospital facilities. The increase in the number of bassinets is the most significant figure to be noted. Attention, however, should be directed to the fact that the results of the Hospital Construction Program are not shown in this decade, but will become more apparent in the next.

Table 10 shows that the greatest percentage increase in the type of hospital facilities was in tuberculosis hospitals, and here again the number of beds will be greatly increased again after the end of the decade.

HIGHLIGHTS IN HEALTH PICTURE
FLORIDA 1940-49

OVERALL DEATH RATE DOWN FROM 11.2 TO 9.5	TREND PROBABLY AIDED BY IMMIGRATION OF WHITES	PNEUMONIA AND INFLUENZA DEATH RATE DOWN FROM 63.6 TO 26.2	BUT NO SATISFACTORY CURE FOR POLIOMYELITIS HAS BEEN FOUND
MATERNAL DEATH RATE DOWN FROM 6.4 TO 1.8	BUT U.S.RATE STILL LOWER 1.0; FLORIDA STILL RANKS LOW	NO. HOSPITALS INCREASED FROM 96 TO 128	
INFANT DEATH RATE DOWN FROM 53.8 TO 33.7	BUT DEATH RATES OVER AGE 50 IMPROVED LITTLE	NO. HOSPITAL BEDS INCREASED FROM 11,845 TO 17,324 (46%)	BUT ABOUT SAME % INCREASE IN POPULATION
DEATH RATES FROM INFECTIOUS DISEASES DOWN	BUT DEATH RATES FROM CHRONIC DISEASES UP	NO. GENERAL HOSPITAL BEDS INCREASED FROM 5,183 TO 7,469 (44%)	BUT ABOUT SAME % INCREASEDIN POPULATION
DIPHTHERIA, WHOOPING COUGH, TYPHOID FEVER, DYSENTERY, MALARIA, AND TYPHUS FEVER DEATH RATES (COMBINED) DOWN FROM 12.0 TO 2.1	BUT REPORTING OF CASES OF COMMUNICABLE DISEASES BY PHYSICIANS REMAINS UNSATISFACTORY	NO. TB. BEDS INCREASED FROM 595 TO 1,139 (91%)	
		BASSINETS INCREASED 745 TO 1,615 (117%)	
MOTOR VEHICLE ACCIDENT DEATH RATE DOWN FROM 36.8 TO 24.9	BUT UP AGAIN IN 1950 TO 30.6 (PROVISIONAL FIGURE)		
OTHER ACCIDENT DEATH RATE DOWN FROM 53.3 TO 37.8	ACCIDENTS TAKE THE LIVES OF OUR MOST HEALTHY AND PRODUCTIVE CITIZENS	SUBSTANTIAL PROGRESS MADE IN DECADE IN PUBLIC WATER SUPPLY, SEWAGE DISPOSAL, STREAM POLLUTION, MOSQUITO CONTROL, RESTAURANT AND MILK SANITATION, NUTRITION AND HOOKWORM CONTROL, NARCOTICS, MENTAL HEALTH, ANIMAL-BORNE DISEASES	BUT: THESE REMAIN GREAT PROBLEMS FOR THE FUTURE ALONG WITH: MATERNAL DEATHS, PREMATURE DEATHS, DISEASES OF OLD PEOPLE, (CANCER, HEART DISEASE, DIABETES,) NEGROES, ACCIDENTS, POLIOMYELITIS
TUBERCULOSIS DEATH RATE DOWN FROM 50.8 TO 25.4	BUT CANCER DEATH RATE UP FROM 91.0 TO 121.4		
SYPHILIS DEATH RATE DOWN FROM 16.9 TO 7.4	BUT REPLACED BY DIABETES IN FIRST 10 CAUSES OF DEATH		
CARDIO-VASCULAR-RENAL DISEASE RATE DOWN FROM 485.8 TO 469.7	BUT HEART DISEASE DEATH RATE UP FROM 270.1 TO 308.5. COULD BE CHANGE IN DIAGNOSIS?	OVERALL HEALTH SITUATION IMPROVED VERY MARKEDLY	FUTURE OUTLOOK VERY BRIGHT INDEED

Table 11

In the interest of brevity and conciseness I have presented in table 11 the highlights in the health picture in Florida in the period from 1940 to 1949. I have attempted here to emphasize the good and the bad, the favorable and the unfavorable by balancing facts on either side against each other. I take great pride, both as your State Health Officer and as a member of this Association, in the fact that when the favorable and unfavorable factors are weighed critically, the balance is in favor of the favorable. The facts and figures shown present a challenge to all of us to continue the work that we are doing and to improve it so that when we measure our accomplishments during the present decade, 1950 to 1959, we can show even greater strides towards improving the health and lengthening the lives of our people.

1217 Pearl Street.

Stevens-Johnson Disease
Report of a Case

R. RENFRO DUKE, M.D.
TAMPA

When Stevens and Johnson,[1] in 1922, described 2 classic cases of a "new eruptive fever associated with stomatitis and ophthalmia" occurring in children, they aroused interest which has steadily increased in the syndrome that has come to bear their names. Because of its relative rarity and the confusion in nomenclature, it is unfamiliar to the average physician and is therefore frequently incorrectly diagnosed. The ophthalmologist may well familiarize himself with the clinical picture for serious, even disastrous, ocular sequelae may occur. Likewise, it is important that the rhinologist become acquainted with this syndrome, for he may be consulted first by the patient because of the early symptoms of a badly infected mouth and pharynx suggestive of severe Vincent's angina or stomatitis caused by a blood dyscrasia.[2] Once one has encountered a typical case, however, the various clinical features fall into a pattern difficult to mistake thereafter.

Nomenclature

Two schools of thought exist regarding Stevens-Johnson disease. Some authors consider it a severe form of erythema multiforme exudativum (Hebra), and others believe it is a definite clinical entity. Some attempt to separate the cases with a catarrhal conjunctivitis from those with purulent conjunctivitis, and others prefer to place those with bullous or macular lesions in different groups. So formidable is the array of cumbersome names which clutter the literature that various authors regard classification as impossible. Despite the protean clinical and laboratory picture, however, multiform lesions of the skin and mucous membranes, conjunctivitis and constitutional symptoms compatible with an acute infectious disease are the criteria demanded by all.

As early as 1822,[3] a disease was described in France which Hebra,[4] in 1866, named erythema multiforme exudativum. He mentioned involvement of the mucous membranes, but did not stress the occurrence of conjunctivitis of a serious type. Fuchs,[5] in 1876, first emphasized the ocular involvement and introduced the term, herpes iris conjunctivae. Other descriptive terms adding to the confusion include ectodermosis erosiva pluriorificialis, dermatostomatitis, erythema multiforme pluriorificialis, fatal bullous dermatitis, erythema bullosum malignans — pluriorificial type, mucosal respiratory syndrome indicating involvement of the respiratory tract, erythema multiforme bullosum with mucosal involvement, variations of the Stevens and Johnson eruptive fever with stomatitis and ophthalmia, and simply Stevens-Johnson disease.

The types of conjunctival involvement associated with erythema multiforme were classified by Duke-Elder[6] as catarrhal, purulent and membranous. He regarded the purulent type as rare and much more severe than the catarrhal and identified it as Stevens-Johnson syndrome. It seems

President's address, read before the Florida Society of Ophthalmology and Otolaryngology, Twelfth Annual Meeting, Hollywood, April 22, 1951.

warranted to accept this syndrome as a separate entity, appropriately designated Stevens-Johnson disease. As pointed out by Bradlow and Schless,[7] this term should apply in cases otherwise unclassifiable, presenting (1) constitutional symptoms resembling an acute infectious disease; (2) multiform erythematous skin lesions, predominantly of a maculopapular nature; (3) a purulent conjunctivitis without the formation of an ocular membrane; and (4) a stomatitis. Murphy[8] was of the opinion that recognition of the syndrome in its own right constitutes the greatest progress to date.

Incidence

The age incidence reported by Kahn, Lacer and Stoecklein[9] was between 22 months and 19 years. Thomas[3] reported the commonest age in Great Britain as the early twenties. In the case reported by Jones, Talbot and King,[10] the patient was a woman 56 years of age. In my case the patient was a woman aged 42 years. Few cases, however, have been reported in women. The disease occurs most frequently in children and young men. Some authors have remarked on the infrequency with which the syndrome is observed in Negroes.[9,11] A definite seasonal incidence has also been mentioned, with occurrence more frequent in the spring and fall.

Clinical Picture

This acute systemic disease usually has an abrupt onset and appears to be self-limited although subject to recurrences.[12,13] It is characterized by headache, anorexia, joint aches and pains, chilly sensations and fever, with the elevated temperature ranging from 102 to 106 F. and sometimes persisting for weeks. Coryza, pharyngitis, bronchitis, tracheobronchitis, bronchopneumonia, moderate to severe deafness, hematuria, urethritis, balanitis, generalized lymphadenopathy and splenomegaly, lesions of the anal mucosa, malaise, weakness, prostration and mental confusion have been reported.

Cutaneous eruptions, stomatitis and conjunctivitis are of course the outstanding symptoms. The lesions of the skin and mucous membranes appear almost simultaneously on a large macular or maculopapular erythematous base, which usually becomes denuded and crusts over. They resolve into deep purple and brown areas which eventually fade. Stomatitis may be especially severe. The oral lesions usually begin as small vesicles which rapidly burst and become shallow ulcers; a membranous slough forms which leaves a raw buccal and palatal surface. The diffuse conjunctivitis with a sticky purulent exudate may be the first symptom, as in the case here reported. It varies in severity and may predispose to the most serious complication of the disease — panophthalmitis and permanent destruction of the eyeball. It therefore constitutes, in the light of present knowledge, the major point of therapeutic or prophylactic departure. Stevens and Johnson[1] and other authors have reported intense anterior uveitis and perforation of corneal ulcers with resulting phthisis bulbi. Superficial, and in some instances deep, corneal vascularization may accompany healing of the corneal ulcers, with resulting faint nebulas to dense opacities and great visual loss. In some severe cases, as in the case presented here, symblepharon formation occurs, with subsequent distortion of the eyelids. Obstruction of the lacrimal flow by dense conjunctival adhesions with resulting keratoconjunctivitis sicca has been reported; in this case, [14] recurrent corneal ulcers followed the keratoconjunctivitis sicca, with perforation of an ulcer and loss of the eye.[15-18]

The patient with Stevens-Johnson disease is acutely ill. The pronounced constitutional symptoms serve to distinguish this entity from erythema multiforme exudativum (Hebra). Early diagnosis is therefore imperative in order that proper treatment may be instituted in an attempt to prevent permanent ocular damage.

Etiology

The etiology of this disease remains obscure, and pathologic findings have been noncontributory. Cultures have yielded only secondary invading pyogenic organisms. Repeated efforts have been made to isolate a virus without success. Avitaminosis has been suggested as a causative factor, and a possible relationship to mumps has been mentioned. Kahn and his associates[9] recently concluded the consensus is that the process is a sensitivity reaction of certain persons to any one of a variety of allergens, which may include foods, drugs and many toxic substances. They believed that the sensitizing agent in 1 of their cases was embalming fluid, in another, sulfadiazine, and in still another the red dye, apparently cinnabar, used in tatooing. Their bacterial studies, however, including throat and conjunctival smears and cultures, revealed only the usual flora of these locations, and no inclusion bodies could be found on smear. Thus their conclusions conformed with previously expressed opinions that eliminate a specific infection. Shaffer

and Morris[19] reported a case resulting in total permanent blindness due to bilateral involvement of the cornea in a patient treated with trimethadione (Tridione). Fanney[17] mentioned that the disorder occasionally follows vaccination.

Howard and Wible[20] were of the opinion that "pathology of the nose and throat is undoubtedly a greater factor in the etiology of erythema exudativum multiforme than is generally realized." They attributed the disease in half of their series to sensitization by chronic infection in the tonsils and sinuses and regarded eradication of these foci as good prophylaxis against repeated attacks. Elfman[2] regarded the condition as probably infectious in origin and suspected that thirty carious teeth may have been responsible for the systemic intoxication in his case, in which there were four relapses with the patient still retaining the carious teeth. In 1 case reported by Duggan and Gaines[21] there was purulent discharge from the ears as well as from the eyes.

Pathology

Thomas[3] stressed the paucity of constant pathologic findings. The skin and mucous membranes, however, react similarly, exhibiting a typical nonspecific acute inflammatory process. Edema, congestion and hemorrhage characterize the inflammatory reaction, and there follow round cell infiltration and finally exudation of fluid splitting the cell layers, with formation of vesicles and sloughs. Only a nonspecific inflammatory response has been observed on examination of sections of enucleated eyes.[18]

The white blood cell count varies from leukopenia to pronounced leukocytosis, but usually there is an increase in neutrophils.[17] Patz[18] reported persistent leukopenia and thrombocytopenia.

Treponema vincenti, Staphylococcus aureus and Streptococcus hemolyticus are among suspected organisms.

Differential Diagnosis

Many drugs may cause a reaction resembling that of Stevens-Johnson disease. The drug eruptions may be difficult to distinguish, but are usually not as extensive or severe. The sulfonamide compounds, barbiturates, phenolphthalein, iodine, inorganic arsenic and antipyrine most commonly cause bullous eruptions.

Pemphigus vulgaris may be differentiated by the gradual onset, chronic course, older age incidence and absence of tracheobronchial involvement. Other diseases less commonly causing confusion are aphthous stomatitis or "foot and mouth disease," Vincent's angina, chickenpox and vitamin B deficiency. Hemorrhagic measles, diphtheria, smallpox, impetigo, dermatitis herpetiformis, agranulocytosis, septicemia with generalized eruption, Reiter's disease and secondary syphilis have also been mistakenly diagnosed.

Treatment

There is no specific treatment. General and local supportive measures and the administration of penicillin or other antibiotics are accepted therapy. Strict oral hygiene must be undertaken. Facilities for emergency tracheotomy or intubation should be available when there is extensive involvement with laryngeal lesions and possible obstruction. Boric acid compresses and topical application of 1 per cent gentian violet may be applied to lesions of the skin and genitalia.

Bland solutions and instillations of the antibiotics are used for frequent conjunctival irrigations to combat secondary infection. Ocular complications receive routine symptomatic treatment, with particular regard at all times for the corneal epithelium. Kahn and his associates[9] used boric acid eyewashes, 30 per cent sulfacetimide solution every six hours, penicillin ointment every six hours, and atropine ointment every eight hours.

The efficacy of antihistaminic drugs has not been established. These drugs have been favorably reported on, however, by a number of investigators and strongly recommended by some.[18]

Aureomycin therapy was no more effective in the experience of Kahn and his associates[9] than sulfonamides, and 1 patient in their series who received no therapy except boric acid eyewashes, hydrogen peroxide mouthwashes and intravenous



Fig. 1. — Ulceration of the mucosa of the mouth and lips.

fluids responded as well as any of the others. In my case aureomycin seemed to improve the corneal ulceration temporarily, but always regression ensued. In the current issue of the American Journal of Ophthalmology, Bleier and Schwartz[22] reported dramatic response generaly and locally with cortisone, which was substituted for intensive aureomycin therapy in their case. The conjunctivitis cleared completely after the first three injections.

The prognosis in general is good. Fatal outcome is rare. Most patients recover completely, but some remain blind. As a prophylactic measure against recurrence, a thorough investigation of all foci of infection after the acute phase of the disease has subsided has been recommended.



Fig. 2.— Cutaneous eruptions over the face and neck.

Report of Case

Mrs. R. P., a white woman aged 42, was admitted to the Tampa Municipal Hospital acutely ill on May 28, 1949. The chief complaints were a severe skin eruption, high fever and badly swollen eyes. She was one of eight children and was the mother of five children, all of whom, including her parents, were in good health.

The first symptom, noticed two days prior to admission, was a puffiness with slight soreness around the eyes. At about the same time an erythematous rash appeared over most of the body. On May 27, the second day of the illness, the entire inside of the mouth was sore, and blisters occurred on the inner side of the cheeks. The lips were cracked and painful. The eyes were more swollen, and the lesions of the skin had increased. The patient was experiencing some cough, malaise and weakness, and she was mentally confused.

Physical Examination. — When she was hospitalized the next day, physical examination revealed a well nourished woman of stated age in a semiconscious condition. The temperature was 104 F., the pulse rate 120, and respirations 26. Bilateral conjunctival infection with some mucopurulent discharge was noted. Areas of the mucosa of the mouth, pharynx and fauces were ulcerated, as were the lips, which had a tendency to bleed (fig. 1). Cutaneous eruptions over almost the entire body were more pronounced on the face, chest, back and tibial surfaces of both legs (fig. 2). These lesions were maculopapular and petechial. The husband said that the skin of her body was a dusky blue on the second day of the illness. She experienced burning on urination, and a profuse vaginal discharge was present. There were lesions on the nasal mucous membranes, and the odor of the breath was fetid. Apparently, the cervical lymph nodes were neither enlarged nor tender. Examination of the chest and heart gave negative results.

Ocular Examination. — When Dr. Wesley W. Wilson called me in consultation on May 30 to make the ocular examination, the eyelids were so edematous that the palpebral aperture was practically closed and it was impossible for the patient to open her eyes. When I attempted to pull the lids apart, desquamation followed, leaving a bloody raw surface. There was a moderate amount of purulent exudate present in the conjunctival sac of each eye, which seemed to be more abundant in the left eye. Both the palpebral and bulbar conjunctivas were injected and chemotic, exhibiting follicles and small pustular lesions (fig. 3). Both corneas were clear. The pupils were normal in size and responded adequately in their reactions. There was no evidence of involvement of the iris or anterior chamber. Because of the acute inflammation and edema, it was impossible to examine the fundi. Coordination relative to visual acuity was not obtainable because of the confused mental state of the patient.

Laboratory Examinations. — Urinalysis revealed albumin 1 plus, specific gravity 1,020, pus cells 15 to 20 per high power field, and sugar 103. The results of examination of the blood were hemoglobin estimation 11.6 Gm. white blood cell count, 11,700 with 78 per cent polymorphonuclears; platelets 160,000, and bleeding time nine minutes. Reaction to the Wassermann test was negative. Cultures of the conjunctival discharge produced a heavy growth of Staphylococcus aureus hemolyticus.

Treatment. — Symptomatic treatment was carried out with the use of codeine and demerol. Since allergy was considered a possible factor, benadryl was administered. Penicillin therapy apparently effected no improvement. Warm, soothing oatmeal baths and lotions were applied to the cutaneous lesions. Barbiturates were employed to induce sleep. Supportive diet and vitamins were given, also glucose intravenously.

Ocular Treatment. — To combat the edema of the eyelids cold compresses were used, and irrigations of the conjunctival sac with boric acid were frequently employed. Penicillin and bichloride of mercury ointments were applied to the eyes.

For a number of days after the onset of the illness, the predominant ocular symptoms were edema, mucopurulent exudate, beefy red injection and chemosis of the conjunctiva. The corneas remained clear and the pupils normal.

Becoming more rational on the fifteenth day of the illness, the patient complained of inability to open the eyes. Examination revealed adhesions between the palpebral and bulbar conjunctiva of each eye, but much more extensive in the left eye. Pontocaine and adrenalin were



Fig. 3.— Initial intense injection of both the bulbar and the palpebral conjunctiva.

instilled in the palpebral fissure of each eye; then, with an iris repositor, adhesions were separated. It was necessary to carry out this procedure at least half a dozen times during the illness. The nurse was instructed to pull the lids apart three or four times a day in order to prevent, as much as possible, the reforming of the adhesions. At the same time, cod liver oil and ointments were being used.

The patient was discharged from the hospital on June 28. Nearly two years have elapsed since then, and there has been continued improvement in her general condition, except for the eyes.

A few days after discharge, the cornea of the left eye became ulcerated and opacification followed (fig. 4), accompanied by superficial and deep vascularization. The cornea of the right eye remained clear. There was pronounced photophobia.

Four weeks after the patient left the hospital, it was again necessary to free the conjunctival adhesions. A large symblepharon developed in the left eye and is still present. The cornea of this eye has not failed to show fluorescein stain up to the present time. The ulceration seems to improve somewhat with the use of aureomycin, but soon afterward regression occurs.

The left eye was subjected to roentgen therapy, 50 r weekly until 800 r had been given. After this treatment the vascularization and infiltration seemed to be reduced, but in a short time the same condition returned.

Two months after the onset of the illness, vision was 20/30 in the right eye and 20/200 in the left eye. After corneal ulceration began, atropine was used constantly in each eye. There was no response to the usual cauterization with iodine and trichloracetic acid.

On September 14, there was evidence of some infiltration in the cornea of the right eye (fig. 5). The patient complained of failing vision in that eye. The cornea did not stain, but there was an infiltration in the stroma.

Both eyes were still injected on November 11. There was, however, no ulceration nor vascularization of the right eye, although this condition was pronounced in the left eye. Vision at that time was 20/100 in the right eye and forms only in the left eye. The exudation had continued to be present all along in both eyes, but was much worse in the left eye.

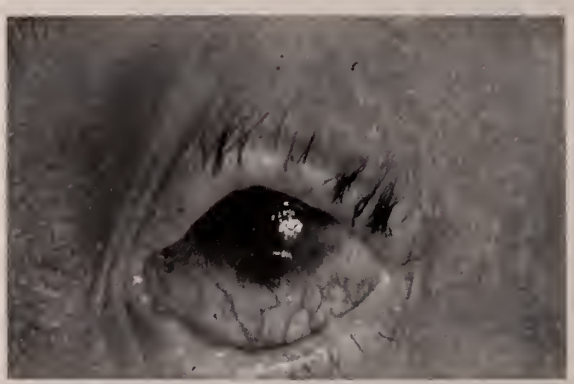


Fig. 4. — Ulceration and opacification of the cornea, which developed six weeks after the onset.

On Feb. 9, 1950, vision in the right eye was 20/200. In the left eye there was only light perception.

Topical instillations of cortisone are now being used and seem to relieve the injection temporarily. Vision in the right eye is sufficient for the patient to navigate, and light perception remains in the left eye. The corneal inflammatory condition is still active, and it appears that total blindness will be the end result.

Comment

Stevens-Johnson disease is a bizarre disease of dramatic onset and course which is apparently self-limited though subject to recurrences. It has been considered primarily the problem of the pediatrician and the dermatologist. A review of the literature reveals a significant increase in the number of cases reported recently, and in view of the high percentage of cases with ocular involvement, it is important that the ophthalmologist be familiar with the syndrome and share responsibility in these cases. As is illustrated by the case presented, it can hardly be overemphasized that this disease is always potentially dangerous to the eyes and may result in complete destruction of vision. There may be simple hemorrhagic conjunctivitis with a purulent exudate or abscess formation affecting some or all structures of the globe. Total permanent blindness following corneal ulceration with perforation occurred in a number of reported cases.



Fig. 5. — Beginning infiltration of the cornea of the right eye. Fundus reflex still good. Corneal opacities so great in the left eye that no fundus reflex is shown.

Summary

Despite confusion in nomenclature and controversy over its status, Stevens-Johnson disease appears to warrant recognition as a separate clinical entity. Of unknown etiology, this systemic disorder is characterized by stomatitis, purulent conjunctivitis, cutaneous eruption analogous to erythema multiforme exudativum (Hebra) and fever. The nomenclature, incidence, clinical picture, etiologic and pathologic considerations, differential diagnosis and treatment are discussed.

A case is reported which illustrates the protean manifestations of this disease and especially the dire ocular sequelae which may ensue. The

ophthalmologist in particular and also the rhinologist and the internist should share interest in this disease with the dermatologist and the pediatrician.

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708 Citizens Building.

Psychiatric Highlights of The First International Congress of Psychiatry Paris, Sept. 18-27, 1950

I. Leo Fishbein, M.D.
Miami Beach

With the blessings of the UNESCO of the United Nations and the French Government, each to the tune of one million francs, the First International Congress of Psychiatry was opened in Paris on Sept. 18, 1950 after three years of intensive preparation by the French committee headed by able Dr. Jean Delay, President, and Dr. Henri Ey, General Secretary. Eighteen hundred psychiatrists from forty-seven nations were present, including about fifty psychiatrists from the United States. Some four hundred from the States had been expected, but the war scare tended to discourage many from making the trip across the Atlantic.

The inaugural meeting of the Congress took place on September 19 in the large amphitheatre of the Sorbonne, with Dr. Jean Delay tracing the progress of modern psychiatry in the various countries from Pinel to the present. Dr. J. Rees of London, on behalf of the English-speaking delegates, recalled the role of the World Mental Health Federation and predicted a great future for this organization and the Congress. Dr. H. Delgrado of Lima, Peru, brought greetings from the Spanish speaking psychiatrists and re-emphasized the historic role of Spain in mental hygiene.

M. Schneiter, Minister of Public Health, thanked all those present who assisted in the organization of this Congress and regretted the absence of delegates from countries that could not be represented. Russia sent no delegates, nor did she allow any of her satellites to be represented. No doubt she feared the delegates might never return to her terror rule.

There was no doubt that this Congress would serve a great need for international understanding of psychiatric disciplines, even though many subjects and opinions would be expressed and considered. The seven main sections were:

1. Psychopathology of Delusions
2. Application of Mental Tests to Clinical Psychiatry
3. Cerebral Anatomy and Physiology
4. Indications for Shock Therapy Methods
5. Evolution and Present Trend of Psychoanalysis
6. Genetics and Eugenics
7. Behavior Problems in Children

Homosexuality was discussed by Dr. Rubinstein of London, who stated that male homosexuality was a crime, but female homosexuality was not. The human being tried to act out all possibilities, both male as well as female. Schizophrenic patients could not realize the whole embrace of male and female partnership. Patients said that there was too strong a strain to get back to heterosexuality and felt that at least they had a halfsex. There was inhibitional maturing. There was a feminine body with a male psyche or vice versa. Dr. Marechal of Tunis stated that homosexuality there was not considered revolting. There was little homosexuality among women since they were so confined and prostitutes were too expensive. Children remained long with their mothers, and so homosexuals among males were encouraged. The Moslem religion did not reprove homosexuality. It might be acquired or constitutional.

Obsessional neurosis was discussed by Dr. James Miller of Chicago, who told of quantitative comparisons under a Rockefeller Foundation study with recording and sound movies of interviews in psychotherapy. Successful treatment effected improvement in objective maturity and a decrease in defensiveness as well as the acceptance of the self as compared with the acceptance of others. A new technic, called the "Q technic" or Inverse Factor analysis, consisted of a series of statements on 250 cards, placed before the patient and sorted into various piles such as attitudes to mother, children, work, fear, thoughts, behavior, waking and so on. There was research planning for a central registry of microfilms, plastics and sound recordings in the United States.

Group Therapy

Group therapy was discussed by Dr. R. Dreikus of Chicago, who outlined the progress made in the past ten years and the problems of each therapist developing his own methods, with special dynamics operating in groups in variable or nonvariable patterns and directive or nondirective forms. Group therapy spread over Europe in the early nineteen-twenties and then stopped. In 1931, Moreno coined the term "group psychotherapy."

There was much variance in guidance centers in the treatment of alcoholics and in the treatment of private patients. A free discussion dealt with values and life situations. In 1946, multiple psychotherapy came into use, two psychiatrists treating one patient, which aimed at individual psychotherapy. Four basic steps in dynamic psychotherapy were presented:

1. The proper association of the patient and the doctor
2. The analysis of what was going on in the patient
3. Insight — the patient understanding what was involved
4. The patient oriented to insight

The ultimate goal in psychotherapy was the reorientation of the patient in values of living.

Dr. H. Ezriel of London gave the psychoanalytic approach. He stated that supportive measures of the doctor could interfere with the treatment. The analyst showed the fantasy needs of the patient and had him gradually give up these needs. The analyst was in a passive nondirected role. A common group tension represented the common denominator of the unconscious fantasies, which gradually became more conscious. The analyst tried to "twist" groups to suit his mechanisms in dealing with unconscious fantasies.

Dr. J. L. Moreno of Beacon, New York, remarked that the group had to be treated as a special phenomenon and that knowledge of the group structure was most important. Psychodrama had been used in Sing Sing and in the armed services with excellent results. It was useful in community life for higher levels of group equilibrium.

Dr. J. Bierer of London discussed individual psychiatry which was turning into social psychiatry.

Dr. Hirschler of Amsterdam studied neurotic soldiers in group psychotherapy. Their "social ego" was disturbed, and they were afraid of social contacts. The adult ego grasped and rid itself of infantile manners.

Dr. S. Lebovici of Paris discussed the experiments in group psychotherapy which started five years ago. Catharsis was the dramatic catalyst.

The technics were group psychodrama, psychoanalytic dramatics and psychoanalytic group. It was important to identify the patient to the group and to identify the attitudes of each to the group with reductive identification of infantile levels and premonitory identification of tensions in groups.

Mrs. J. L. Moreno of New York discussed cohesion of "tele" as necessary for therapeutic success in group therapy. There were natural groups such as families and selected groups such as patients. Treatment changed from a group of low cohesion into a group of high cohesion.

Dr. F. Risques of Montreal discussed "group discharging," which was the releasing of anxiety by discussion of common problems. Hostile patients monopolized the group and caused too much anxiety. Patients remarked they "never knew such helpful people existed."

Dr. M. Torre of New York discussed the choice of a group therapist with basic personality traits, skills and abilities to form good relationships, to be able to handle frustration, to have patience and intuitiveness — all the assets of the "natural group leader."

Dr. W. Freeman of Washington, D. C., discussed lobotomies. "It does not require much frontal lobe to work for a living." The lobotomy patient was a robot and cared little for recreation, lacked social integration and the capacity of imagination and creative zeal. His community effort and executive capacity were usually lost. Dr. Freeman stated emphatically that to be effective, lobotomy had to relieve the patient of his fantasies and restore him to home and society. If it was inadequate, it was useless, and if too extensive, was crippling.

Dr. H. Hecaen of Paris discussed the normal individual who kept himself in "total readiness" while the sick patient did not. While many cortical cells degenerated postoperatively, many transcortical fibers remained intact. The "neurotic automatism" had thalamic connections with the cortex.

Dr. Morgenthaler of Bern, Switzerland, at the Rorschach International Reunion, discussed the plasticity and dynamism of the Rorschach test and the comparison with other projective technics. He pleaded for the harmonious collaboration of psychologists and psychiatrists for better terminology and interpretations over the world.

Dr. E. Minkowski of Paris discussed Existential Analysis in Psychiatry. This embraced many ideas: the manner of being a human, a man, "d'etre humain." "Homme," man, the noun, could not comprehend all. "Etre," the verb, was function, being, action. "Sein" analyzed the structure of being different from a stone, the liberty of creating, the particular of being human, the limit of liberty of a man, the finite life: he lives, he dies. Existence was always a permanent problem — being in the world had tone and color. The idea of the structure of the limits of man was important for psychiatry in existence. The manner of being myself — "c'est moi, l'ego" — "we" singular or together, another "we" in duality. The world of action was like a small hole or a rose, with elements of time, space and movement. In patients the world was colored: rose was for manic states, green was for depressions. The schizophrenic lacked grace, harmony and sentiments. "Being" in the world and "seeing" was important in psychiatric treatment. "Je vois, je sens, je suis." "I see, I feel, I am."

Dr. Shornan discussed Experimental Neurosis by Conditioning, concerning the traumatic war neurosis and delayed conditions in the blitz in England and the Korean war with ruminations about atomic war and the "ether extinction treatment of hysterics." Anxiety and obesity in children during bomb explosion periods were evaluated.

Shock Therapy

Dr. M. Sakel of New York discussed Biologic Therapeutics, Schizophrenia and his original insulin treatment. He stated that insulin and its coma treatment were catastrophic for thousands of patients in 1933 and the opportunity for its use was denied in Berlin. It was finally allowed in Vienna. There was no quick or easy cure. Up to 1937, there was much confusion and misconception. Sakel stated: "Since 1927 I was sure psychologic treatment alone could not serve as treatment and decided to use physiologic therapy. Now, as before, I feel Schizophrenia can only be treated by the laborious method of insulin. Success depends on the detailed procedure plus psychotherapy." He remained critical of electric shock treatment for all mental illnesses. Another method of shock treatment was discussed. It had been used for the past five years and was a gas mixture of 30 per cent CO_2 and 70 per cent O_2, with daily treatments of a series of 10 to 100.

Dr. M. Fiamberti of Italy discussed acetylcholine shock treatment in 311 cases with 80 per cent cures in over eight to twelve years' follow-up, 14 per cent relapses and 6.7 per cent recurrences. He

re-emphasized that science only becomes dangerous when it is thought to have reached its aims.

Dr. V. Cerletti of Rome, originator with Dr. Bini of electric shock treatment, discussed this form of therapy. It was best to have a complete convulsion which gave more force to the therapeutic goals. These phenomena affected the whole animal, not only in the brain but in internal complicated reactions. Much research in Rome was being continued with greater applications in neurophysiology.

Dr. J. Lopez Ibor of Madrid admitted that electric shock itself did not cure schizophrenia but that it shortened the illness and lessened the suffering of patients and therefore was justified. He reminded the audience that this therapy might aggravate a catatonic patient into agitation, but would improve the patient clinically.

Dr. L. Rees of Cardiff, England, stated that schizophrenia was one of the most perplexing problems facing psychiatry. He admitted a good prognosis depended on many factors, among them a good personality previously, a short illness, atypicality and broad interests; that insulin gave best results in sixteen weeks of treatment compared to the hospital stay at least twice that without treatment. Electronarcosis and electric shock treatment produced less satisfactory results in over 240 cases of schizophrenia. Those who had been sick over three years with poor response to any therapy had poor prognosis. Leukotomies that were performed on patients with poor prognosis, and after all other methods failed, resulted in recovery in 4 per cent, improvement and discharge in 24 per cent, improvement with the patient remaining in the hospital in 12 per cent, and no improvement in 60 per cent.

Dr. G. Heuyer of Paris showed films of neuropsychiatric conditions in children as chorea, hysteria, mental retardation, infantile schizophrenia with hallucinations and delusions, affective disorders of mania, depression and tics.

Rene A. Spitz of New York presented a film of children entitled "Grief" and emphasized the psychic trauma involved in losing a mother. If the period of separation of the child from its mother was less than three months, there was a 12½ per cent reduction of development. If the period was three to five months, there was a 14 per cent reduction, and if it was over five months, there was a 25 per cent reduction. The emotional climate of the mother was absolutely needed for the normal development of children.

Dr. H. Pittrich of Frankfort, Germany, presented a film on Post-Traumatic Aphasia with difficulty in recognizing objects or words. The patient recognized "Koln" (Cologne) as a city in Germany, described it in detail but could not name it. If asked to write 4 divided by 2 he did thus: 4:2=2. When asked to multiply 4 by 2 the result was: 4:2=8. When asked to add 4 and 2 he did thus: 4:2=6.

Psychoanalysis

Dr. Franz Alexander of Chicago reminded the Congress that the "heroic" phase of psychoanalysis belonged to the past. Humility was becoming to all scientists, he observed, and prolonged "interminable" treatment was a danger in orthodox therapy. He stressed that regressive dependence of the patient to the therapist must not be prolonged to interfere with the patient's will to be cured. To this end, he had, over a period of twelve years, shortened the psychoanalytic process and was pleased with the favorable results. He elaborated as follows upon the ego's basic functions, whose failures caused mental illness:

1. The internal perception of needs
2. The external world needs
3. The integrative faculty — how the ego integrated to the environment
4. The executive faculty that kept the self (ego) in coordination and adapted itself to external situations

He re-emphasized that psychoanalytic treatment aimed at integrating and mobilizing all defenses toward emotional reconditioning. Mastery through insight was the key to successful therapy. "My critics accuse me." They did not call this method psychoanalysis, called it something different, it was good but ——. He stated that he could be at peace with his critics, but he would not be at peace with himself. It was strictly semantics. He stated that his method was not a new technic in psychoanalysis and most of the details were used by most analysts and often inadvertently. He hated the term "orthodox psychoanalysis." Dr. Alexander re-emphasized that the therapists' aim was to bring a change in the personality, to allow the patient to resolve the past actual conflict as rapidly as possible by transference and countertransference and develop a strong independent personality. The transference was the motor of the therapeutic action. Dr. Alexander discussed a

published case with similar therapeutic results in a patient seen for thirty-nine sessions in one year and one seen every day for the same length of time. He concluded: "I hate 'You can't do this or that, you must try!'" The doctor stressed the fact that the psychoanalytic dependence technic might prolong the neurotic illness; as Freud said, "Some patients come to me later, not to be cured but to be treated." Dr. Alexander advocated shorter periods and longer interruptions and earlier tapering off. It is rather amusing and ironic that a movement was on foot to excommunicate him.

Dr. M. Levine of Cincinnati discussed the training of psychoanalysis and development of psychosomatic medicine and correlations between conflict situations and physiologic responses; dependency and protection symbiotic with a big powerful, parent figure. He stated that most patients had problems in three spheres:

1. Sexuality trends
2. Hostility
3. Dependency

He concluded that there was an extraordinary closeness of psychiatry, psychoanalysis and psychosomatic research.

Anna Freud of London, daughter of the famed Sigmund Freud, discussed the stormy times and difficulties in psychoanalytic work during the past twenty-five years. In the psychoanalytic field the personal interpretation goes on constantly with some analysts pursuing theoretic ambitions. The role of the father was most important during this period; now only the role of the mother is most important, and we wonder if the father role is at all significant. Light is constantly shed on the child's ambivalence — an alternation between positive and negative action. The ego functions have been carefully studied in recent years. The production of anxiety as a normal function of the ego is now an accepted fact, whereas previously, it was thought to be a neurotic manifestation. The ego must be equipped to deal with anxiety. Educators try to bring up children with no anxiety and no fears, which is a mistake. What is most important is how the child learns to use his defenses, not whether there is too much or too little repression. Future education must encourage the ego development of the child with a new evaluation of childhood. The transference neurosis enabled the therapists to penetrate into the deeper layers of the patient's mind. What happened in the first year of life was the slow growth and development of the ego. The center of awareness was the ego. The "experience of pleasure and unpleasure" became connected with objects in the outside world, moving and changing. The outset of conflict and anxiety is in a growing curve as the ego grows. The therapy of anxiety is incomplete unless it is with study of the development of the ego.

Dr. R. de Saussure of New York discussed the case of Pierre, a 36 year old man, who was afraid his older brother, Jean, had tuberculosis and might die as his father had. Jean was afraid God was punishing him. Pierre adored his brother and promised God he would never touch a woman or tobacco. Painful stimuli resulted in hallucinations and mental disintegration. The hallucinatory elements were isolated, and the repressed material was brought to consciousness. Infantile defenses changed into adult integrations with successful therapy. Dr. de Saussure also discussed the "analytic dialectic" dialogue between the patient and the doctor with the gradual realization of emotions coming up which were associated with the past.

Dr. M. P. Benassy of Paris discussed various treatments in psychiatry and psychoanalysis in different countries. The Portuguese had no strict analytic psychiatry. The Czechoslovakians interpreted economic and social changes on psychoneurotic patients. The Belgians and Peruvians opposed the sexuality importance. The Dutch analysts gave up daily sessions. The Brazilians opposed Alexander and preferred more strict psychoanalysis while the French preferred short psychoanalytic periods.

Dr. J. Bierer of London remarked that the analytic "fashion" was blowing like a tornado in the United States, that there was a hiatus between full insight and cure, that schools differed still, that analysis had ceased to be the only treatment and that the era of Social Psychiatry was taking the place of Individual Psychiatry.

Melanie Klein of London discussed ego and superego development in the infant's emotional life and her analytic work with children and adults. She maintained that the earliest form of anxiety was of persecution and that ego integration began in the second part of the first year.

Dr. Ch. Oder of Lausanne, Switzerland, discussed the "phenomenological aspects of conflicts," some archaic and some progressive. He stated that the genesis of the ego was linked to the genesis of neurosis.

Dr. S. Burbano of Barcelona, Spain, did not think that psychoanalysis was a finality, that there were many changing theoretic concepts of dreams

and personality. Anthropologic research was of great value in mental health study. Future psychoanalysts in his opinion will be social therapeutists.

Social Psychiatry

Dr. F. Kallman's paper on Social Psychiatry was discussed in its polydimensional attitudes toward human behavior problems, and the interaction of predispositional and environmental causes. Dr. Kallman included in the broad term, schizophrenia, the atypical, mixed and "pseudoneurotic" types. He discussed the increase in the blood relatives of manic depressive and schizophrenic patients and observed that monozygotic twins were more susceptible to manic depressive or involutional psychoses. The involutional psychoses were genetically related to the schizoid personalities and to schizophrenia. Recessiveness occurred in schizophrenia while dominance occurred in manic depressive psychoses. About 60 per cent of manic depressives came from the mating of one manic depressive and one normal person; the difference was in favor of the stronger trends.

Dr. L. Penrose of London stressed the importance of genetics in the future of Social Psychiatry.

Evolution of Psychiatry

The permanent International Exhibition of the History and Progress of Psychiatry at the Palace of Research (Palais de la Decouverte) was opened by the French Minister of Education, M. Lapie. The exhibition of pathologic art took place at the Saint Anne Psychiatric Hospital.

The evolution of psychiatry was represented from the Greek-Roman medicine of Vitalism and Empirism to the "Removal of the Chains" of the French revolution, and modern disciplines. Outstanding among the numerous films shown were:

1. "Van Gogh" — his life reflected in his paintings
2. "The Demon in Art" — containing the marks of Flemish and Nordic theologic painters, portraying the wickedness of the world
3. "Paradise" — a film of fantasy
4. "The Conflict of Dr. Caligari" — a classical German film of the expressional school

Others included: "The Feeling of Rejection," "The Feeling of Hostility," "Overdependency," "Photoshock — Effects of Luminous Stimulation," "Transorbital Lobotomy," "Electronarcosis Therapy," "Activity Group Therapy" and "Parkinson's Disease."

Table 1. — Psychiatric Progress as Presented at the Congress

Pinel	Treatment	1793
Esquirol	Treatment	1838
	Description of General Paralysis	1854
Broca	Centers of Language	1863
Kraepelin	Nosography	1890-1907
Wagner von Jauregg	Malariotherapy	1919
Freud	Psychoanalysis	1895-1939
Bleuler	Schizophrenia	1911
Sakel	Insulin Therapy	1927-1933
Egas Moniz	Lobotomies	1936
Meduna	Convulsive Therapy	1937
Cerletti	Electric Shock	1938

Dr. G. Lundquist of Stockholm discussed the use of antabuse in the treatment of alcoholics. This compound of sulphur (tetraethyl thiuram-disulphide) most patients tolerated for months in a daily dose without suffering the slightest ill effects. When such a patient drank alcohol, there appeared in nearly every case many unpleasant symptoms which were associated with acetaldehyde formation such as marked facial flushing, increase in breathing and pulse rate with nausea and vomiting and which lasted about one to two hours. The patient received 4 antabuse tablets (0.5 Gm. each) — a total of 2 Gm. The second day, he received 3 tablets, on the third day 2 tablets, and then 1 tablet daily for four to eight months. These treatments were best carried out in the hospitals, and simultaneous psychotherapy was an absolute adjunct for social rehabilitation.

Dr. John Bastock of the University of Queensland traced the history of psychiatry in Australia from the departure from England of 750 convicts under the care of one Captain Arthur Phillip on May 12, 1787, to the present psychiatric disciplines present throughout the land. The Australian Association of Psychiatrists was founded in 1947 and is now an established body holding conferences throughout the Commonwealth.

Dr. Gaston Ferdiere of France discussed the drawing hand of the schizophrenic. The pen was the habitual instrument. "The hand is action, it takes, it creates and often says what it thinks." The drawings remained clear and neat, but stiff and lifeless with rigidity and strength in drawing movements and in colors also.

Dr. M. Roth of England discussed brain electrical activity changes as a result of convulsive therapy. These recordings were carried out one to sixty hours after treatment. The thalamic reticular system was rendered overactive by shock treatment; the highly rhythmic slow waves were

the most constant feature of the response. Shock treatment tended to obliterate the physiologic basis for recently acquired behavior patterns and to restore the more firmly established framework of prepsychotic personality organization. The rhythmic changes reflected a primary influence at a specific localized site in the diencephalon. In a more general biologic sense, electroencephalographic changes may be regarded as a reflection of the rise in activity of a psychogenetically primitive level of the central nervous system.

Dr. P. Reiter of Copenhagen discussed Danish psychiatry. Frederick Lange established a psychotherapeutic atmosphere in his mental hospital. During the period of 1932 to 1937, many psychiatrists fled the terrors of the Nazi regime and came to Denmark. In October of 1946, the Danish Psychiatric Association counted 150 members. During the past five years, there has been a great interest in psychotherapy and analysis. A national mental hygiene association has also been formed using the facilities of the press, radio and films with many clinics for children and adults.

Dr. Rezai of Tehran discussed psychiatry in Iran and reminded the audience that mental patients for centuries have been separated and treated. For the past 3,000 years, the Arabic language has been the literary and scientific language of the civilized world. These mental patients were divided into three groups:

1. The simple of spirit who were believed possessed of celestial power
2. The agitated, enchained in their cells near holy tombs
3. The calm and depressed treated in hospitals

Insulin treatment was started in 1936 and shock treatment in 1946.

Dr. L. B. Kalinowsky of New York discussed Somatic Symptoms in Schizophrenia. Two symptoms among others were evidence of diencephalic imbalance; variations of body weight and menstrual disturbances. In acute cases, loss of weight was spectacular even before overt signs of the psychosis were present. Excessive gain of weight after lobotomy, usually accompanied by excessive eating, was caused by the loss of affect and anxiety. Deteriorating schizophrenics gained weight. Manic depressive patients showed body weight variations in a similar manner to schizophrenics. Psychoneurotics showed less variation in weight. Menstruation usually stopped when the psychosis was in full bloom and lasted for several months after the psychosis cleared up.

Time and space do not permit further consideration of the many excellent papers presented at the Congress. I am eagerly looking forward to the Second International Congress of Psychiatry in one of the Scandinavian countries, probably in Sweden in 1955.

420 Lincoln Road.

MEDICAL DISTRICT MEETINGS

The Chairman of the Council, Dr. William C. Roberts, has announced that the dates of the Four Medical District meetings have been officially set by the Council.

Every member of the Association is urged to attend the meeting in his district and any of the other three meetings as desired.

Pensacola, Oct. 22, 1951
Bradenton-Sarasota, Oct. 24, 1951
Vero Beach, Oct. 25, 1951
Orlando, Oct. 26, 1951.

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The Journal of the Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION

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September Anniversaries

SEPTEMBER 10. Born near Dorchester, England, son of a landed proprietor, Thomas Sydenham was baptized on Sept. 10, 1624. Disregarding Harvey and Vesalius, but depending upon Hippocrates and his own observations at the bedside, Sydenham became one of the greatest figures in internal medicine of that early era. He wrote classical descriptions of chorea, hysteria, gout, measles and scarlatina. His original essay on chorea could hardly be improved upon today.

Sydenham was one of the first to soft pedal medication and advocate fresh air in the sick room, particularly for tuberculosis. Dr. John Brown called him "the prince of practical physicians." Others have emphasized that he was conspicuous for good humor, piety and good sense.

SEPTEMBER 13. Major Walter Reed was born on Sept. 13, 1851. Chief of the Army Board which was sent in 1900 to study yellow fever in Cuba, he with J. W. Lazear, James Carroll and Aristide Agramonte through brilliant, self-sacrificing work promptly demonstrated mosquito transmission of the disease, which exploded the theory that it was bacillary in nature. Two of the members of the board contracted the disease, and Lazear died a martyr's death.

Prior to that time Florida had suffered several devastating epidemics and was threatened with the disease almost every year. People believed that



Walter Reed,

From a photograph taken in 1901. Ætat 50

Courtesy, Kelly: Walter Reed and Yellow Fever, Baltimore, The Medical Standard Book Company by The Williams & Wilkins Company.

the hot summer climate was responsible for the contagion, visitors did not remain after the first warm spell of spring, and capital would not make investments for year round operations. Through the application of Walter Reed's findings yellow fever was promptly conquered, and foundations were laid for Florida's phenomenal development during the twentieth century.

September 14. Ivan Petrovitch Pavloff was born on Sept. 14, 1849. His work chiefly in three fields, physiology of the circulation, physiology of the digestion and conditioned reflexes, was crowned with the Nobel Prize in 1904 and worldwide adulation in 1935 during the International Physiological Congress in Moscow.

Pavloff worked continuously in Russia. Totally indifferent politically to the present Russian government, he was, however, the great scientific hero of the U. S. S. R. It is amusing to note that under the Czarist regime funds to support his research were derived from sale of the purified gastric juice of experimental animals, especially in demand after feast days.

September 23. The Royal College of Physicians of London was founded by Thomas Linacre in 1518.

September 23 and 7. William S. Halsted was born on Sept. 23, 1852, and died on Sept. 7, 1922. Brought to Baltimore for temporary assignment, he became one of the four great leaders at the Hopkins during its early years.

Precise and meticulous to the last degree, Dr. Halsted became the chief American exponent of slow, methodical, careful surgery demonstrated by Theodor Kocher in Bern. Nowhere was the delicate art of the perfect healing of wounds demonstrated more beautifully than in his clinic.

The story of the introduction of rubber gloves in surgery by Dr. Halsted is fascinating, and his pioneering experience with cocaine is exciting, although somewhat tragic.

Dr. Halsted's meticulous technic in surgery was carried out in his whole conduct of life, dress and manners. So formal and polite was he that some of his beginning students wondered if he were poking fun at them.

It is a treat to hear some of his early students give their impressions of "the Professor." In recent articles, Dr. McClure captures charmingly the spirit and inspiration of Dr. Halsted during his best years.[1] Perhaps his best biographer is W. G. MacCallum,[2] from whose book "William Stewart Halsted, Surgeon" is taken the accompanying photograph of this great man of medicine.

1. McClure, R. D.: The Halsted School of Surgery, Alexander Blair Hospital Bulletin 6:51-59 (May) 1947; — and Szilagyi, D. E.: Halsted — Teacher of Surgeons, Am. J. Surg. 82:122-131 (July) 1951.
2. MacCallum, W. G.: William Stewart Halsted, Surgeon, Baltimore, The Johns Hopkins Press, 1930.



Photo by John H. Stocksdale

Dr. Halsted in 1922

Courtesy, MacCallum: William Stewart Halsted, Surgeon, Baltimore, The Johns Hopkins Press.

"The Glandular Mr. Ewing"

"Sign," the magazine which recently was awarded a gold medal as the best Catholic magazine of general circulation, published an interesting article in a recent number about Oscar Ewing. Written in popular vein, it was titled "The Glandular Mr. Ewing." Evidently the title was prompted by the picture caption, direct quotes from the Federal Security Administrator: "I am not afraid of controversy. I like it. It does something to my glands."

Would that it might do something to his thinking by way of Americanizing it.

Cures for Ailing Freedom

When Dr. Louis H. Bauer of Hempstead, N. Y., was unanimously chosen president-elect of the American Medical Association at the one hundredth annual session held in Atlantic City in June, he stressed in his speech of acceptance the need for continued vigilance by the medical profession to preserve the ideals already achieved and to develop further constructive action to maintain the freedom of the profession. He wisely emphasized that physicians can no longer be purely scientific in their viewpoints but should assume a wider role as citizens interested in the general welfare of their communities and their country at large. This reminder cannot be reiterated too often.

During the A.M.A. session a stirring lay message aroused particular interest. Representing that vigilant champion of freedom, the country press of America, Edwin F. Abels, publisher of the Lawrence, Kansas, Outlook, and past president of the National Editorial Association, addressed the Conference of Presidents and Other Officers of State Medical Associations on the subject "An Editor Views Medicine." He told an overflow crowd:

"It has been said before, and I only repeat it, freedom in this nation is being poisoned. It is sick unto death. The editors of the papers I represent have known this fact and have been concerned about it. It never occurred to them to call in the doctor to help cure this case of poisoning. Foolishly, they kept calling on the politicians, some of the very men who were mixing the libation. What a thrill it was when you men walked in, unannounced, and told the world to count you on the side of freedom, liberty, private initiative and all of the privileges and opportunities that have contributed to the greatness of this nation. Yet it was the natural thing for you to do. History tells us that yours is a profession built by men of courage, vision and great intellect. . . .

"What America needs today, what your profession and my business need, more than any other one thing that I can call to mind, is men of courage to speak out fearlessly and courageously for what they know to be right. You did it in your advertising campaign and you inspired thousands of others to follow your example. By that campaign you won new prestige. Brave men must hold high the torch of liberty.

"Our American system of government is based on the right of the individual under the law. It is based upon the tenets of Christianity, the Ten Commandments, the Sermon on the Mount, the Golden Rule — aye, on the very principles enunciated by Hippocrates a half century before the birth of Christ. Our system of government is based on reason and common sense and the dignity of man. . . .

"Through our combined efforts we must somehow, some way rekindle in the heart of every true American that spark of patriotism so necessary to good citizenship in our republic. We must never lose sight of the fact that free enterprise made America great and free enterprise will keep America great. We must speak up for America and her institutions at every opportunity. . . . We must do all within our power to preserve our constitutional form of government. We must live our daily lives to the honor and glory of God whose universal laws are the cornerstone of the nation we love. If we do all of these things, then you and I and those who follow can continue to enjoy the blessings of this great liberty-loving nation."

How right Mr. Abels is.

A. M. A. President to Visit Florida

The nation's Number One Medical Leader is coming to Florida. Dr. John W. Cline, President of the American Medical Association, will be in Miami the weekend of October 5-7, where he will be the guest of the Florida Medical Committee for Better Government and principal speaker at the committee's second annual meeting.

"Dr. Cline's visit will give Florida physicians an enviable opportunity to hear, meet and know medicine's leader. We feel we have been signally honored in having the A.M.A. president accept our invitation," said Dr. R. B. Chrisman, Jr., state committee chairman.

As The Journal went to press, a meeting of the executive board of the committee had been called for August 12 in Orlando to make final arrangements for Dr. Cline's visit. Tentative plans for the weekend include a luncheon, a dinner and other affairs for committee members and guests. Arrangements also were being made so that Florida doctors in Miami for the meeting could attend

the Florida State University vs. University of Miami football game on Friday night. The committee also will present Dr. Cline at a public meeting.

The FMCBG will extend invitations to all members of the Florida Medical Association to attend the meeting and welcome the A.M.A. president. Committee members also are inviting Florida doctors and their wives not already enrolled as members to join with them and receive Dr. Cline.

General chairman for the meeting is Dr. Edward R. Annis of Miami, with Dr. Homer L. Pearson, Jr., serving as advisor.

The dinner will be at 6 p.m. Saturday, October 6 in the Columbus Hotel. A business session has been set for 9:30 a.m. Sunday, October 7, to be followed by luncheon, and the public meeting will be at 2:30 p.m. Sunday in Miami's Bayfront Park Auditorium.

Dr. Cline was born at Santa Rosa, Calif., July 2, 1898. He attended public schools in California and received his A.B. degree from the University of California in 1921. He received his medical training at Harvard Medical School, where he obtained his M.D. degree in 1925. He was surgical house officer at the Massachusetts General Hospital in Boston for the next two years and a resident surgeon at Bellevue Hospital, New York, for the two years following.

He then established his practice in San Francisco, where he has resided since. He now is associate clinical professor of surgery, Stanford University School of Medicine; surgeon to the Stanford, San Francisco and Children's Hospitals, and a member of the board of trustees of St. Francis Hospital there. He is a Fellow of the American College of Surgeons and is certified by the American Board of Surgery.

During both his medical schooling and his active practice he has written scientific articles, his earliest in 1925 and his latest this year. He currently has a number of additional papers on surgical subjects in preparation.

Always a student of the economic side of medical practice, he has served as a director and as president (1942) of the San Francisco County Medical Society. He was an elected member of the California Medical Association Council from 1940 to 1946, during which time he served as chairman of the auditing committee and chairman of the executive committee. He was president of the California Medical Association in 1947-48.

Dr. Cline since 1945 has served as a member of the American Medical Association's House of Delegates, the policy-forming body of the A.M.A. He is a member of the A.M.A. Coordinating Committee, which is directing the association's educational campaign.

He was a United States delegate to the World Medical Association in 1948 and 1949. He is a member of the San Francisco Surgical Society (president in 1947), the California Academy of Medicine, and the Pacific Coast Surgical Association, and was unanimously chosen president-elect of the A.M.A. in 1950. He assumed the presidency at the annual meeting in Atlantic City in June, 1951.



John W. Cline, M.D.

1951 A. M. A. Convention

Attendance at the 1951 annual meeting of the American Medical Association in Atlantic City June 11-15 maintained the high records established in recent years. The total registration was 28,396 of which 12,229 were physicians. While the overall registration was slightly higher than the 23,777 at San Francisco last year, the number of physicians in attendance in 1951 exceeded that of 1950 by 1,988.

Retiring president, Dr. Elmer L. Henderson of Louisville, declared that the "medical profession had met the threat of socialized medicine with an accelerated, positive program designed to advance the health of the nation." He then listed 15 long-term projects for those who follow him to carry out.

The inaugural address of Dr. John W. Cline, San Francisco, incoming president, which dealt mainly with the aims and objectives of the A.M.A., was broadcast nationwide over Mutual and ABC networks.

Dr. Louis H. Bauer of Hempstead, N. Y., who has been chairman of the Board of Trustees, is the new president-elect. He will be succeeded as chairman of the Board by Dr. Dwight H. Murray of Napa, Calif. Dr. Oscar B. Hunter of Washington, D. C., was elected vice president. Re-elected to office were: Drs. J. J. Moore, Chicago, Treasurer; F. F. Borzell, Philadelphia, Speaker of the House; James R. Reuling, Bayside, N. Y., Vice Speaker; and George F. Lull, Secretary.

The 1952 meeting will be held in Chicago. Sites chosen for subsequent years are New York in 1953 and San Francisco in 1954.

As a result of several resolutions introduced into the House of Delegates, the Board of Trustees has announced that Whitaker and Baxter will continue to direct the National Education Campaign through 1952 on a half-time basis.

Representing the Florida Medical Association at the Atlantic City meeting were its three delegates: Dr. Louis M. Orr, II of Orlando; Dr. Homer L. Pearson, Jr. of Miami; and Dr. Herbert L. Bryans of Pensacola. Dr. Orr served as chairman on the House of Delegates Reference Committee on Hygiene and Public Health. Dr. Pearson is a member of the Judicial Council.

Total registration of Association members at the 1951 annual meeting was 136. Members in attendance were: BARTOW: Milo H. Holden. BRADENTON: Lowrie W. Blake, John E. Granade, William D. Sugg, Willett E. Wentzel. CLERMONT: Frederick Jay Fox. CORAL GABLES: C. Howard McDevitt, Jr. DANIA: Fred E. Brammer. DAYTONA BEACH: John D. Browning, Cleland D. Cochrane, C. Robert DeArmas. DUNEDIN: Walter H. Winchester. FT. LAUDERDALE: Frank Denniston, Burns A. Dobbins, E. Borland Gill, Garland M. Johnston, M. Austin Lovejoy, Richard A. Mills, Claus A. Peterson, Francis Dowdle Pierce, Alva R. Taylor, Scottie J. Wilson. HOLLYWOOD: Alexander H. Bluestone, Rudolph W. Heath. JACKSONVILLE: Risden T. Allen, Gordon H. Ira, Thomas H. Lipscomb, Joseph J. Lowenthal, Kenneth A. Morris, Clarence M. Sharp, Wilson T. Sowder. KISSIMMEE: John O. Rao. LAKELAND: S. Allen Clark. LAKE WORTH: Sidney Davidson. LEESBURG: H. Durham Young. MELBOURNE: Theodore J. Kaminski. MIAMI: Reuben B. Chrisman, Jr., Carl H. Davis, M. Jay Flipse, Leon N. Greene, Robert M. Harris, Winston F. Harrison, Ralph W. Jack, Leslie L. Jenkins, Carlos P. Lamar, Louis Lemberg, George D. Lilly, John J. McAndrew, James K. McShane, Stanley Margoshes, E. Sterling Nichol, Benjamin G. Oren, Homer L. Pearson, Jr., Max Pepper, Gerard Raap, Jack O. Rash, Julien A. Rickles, George F. Schmitt, Joseph S. Stewart, Richard F. Stover, Ludwig M. Ungaro, Leo S. Wool, Iva C. Youmans. MIAMI BEACH: H. P. Auslander, Theodore M. Berman, Emmett T. Fitzpatrick, Harold H. Fox, N. Stewart Gilbert, Francis W. Glenn, Meyer J. Glick, Bernard Goodman, Max Gratz, Abraham R. Hollender, Lewis E. Julien, Saul H. Kaplan, Morris J. Levine, Alexander Libow, Rose E. London, Seymour B. London, Meyer B. Marks, David A. Nathan, Cayetano Panettiere, Jean J. Perdue, Maurice J. Rose, Earl R. Templeton, M. P. Travers, Leonard L. Weil, Maurice Zimmerman. MIAMI SPRINGS: Louis C. Pessolano. NAPLES: James A. Craig. OCALA: John J. Cheleden. ORLANDO: Clarence Bernstein, Elwyn Evans, Lewis L. Kline, Pleasant L. Moon, Louis M. Orr, II, Philip F. Simensky, Joseph L. Stecher, Robert L. Tolle. PALM BEACH: Joseph Feldman, Fred E. Manulis, Alvin E. Murphy. PALMETTO: Alva J. Floyd. PENSACOLA: Herbert L. Bryans. ST. AUGUSTINE: A. Clark Walkup. ST. PETERSBURG: Arnold S. Anderson, Dean W. Hart, Robert J. Needles, Robert B. Mertz. SANFORD: Orville L. Barks. SARASOTA: John M. Butcher, Joseph Halton, Melvin M. Simmons, Theodore M. Trousdale. TAMPA: Richard A. Bagby, Harold O. Brown, Joshua C. Dickinson, Nathan L. Marcus, Alfonso F. Massaro, David R. Murphey, Jr., Lee T. Rector, Richard C. Rodgers, Burdette Smith, Alford L. Stone, Morris Waisman. TARPON SPRINGS: James E. Thompson. WEST PALM BEACH: Willard F. Ande, Joseph J. Daversa, C. Jennings Derrick, David A. Newman, Theodore Norley, S. Richard Ombres, Ralph M. Overstreet, Jr., Saul D. Rotter. WINTER HAVEN: Henry F. Keiber. WINTER PARK: Walter B. Johnston.

The Role of the Nursing Home

Recent constructive proposals regarding nursing homes appear to be timely and worthy of full support. The phenomenal growth of these homes during the last decade has resulted from a growing recognition of a pressing need. The increasing number of older persons, the old age assistance programs, the general shortage of hospital beds and the general housing shortage characterizing the forties all increased the demand for such provision for the convalescent, the chronically ill and the aged infirm, who are too frequently also homeless.

The role of the nursing home, not as the present isolated unit but as an important link in a comprehensive chronic illness community program, could go a long way toward solving some of the chronic ills of medical service. Licensed on a practical, realistic basis, affiliated with hospitals willing to provide guidance, consultation and special services as needed, encouraged by community agencies and churches, and especially aided by the cooperation of individual physicians and medical societies, nursing homes could well fill a gap that would bring more medical care, far greater rehabilitation and fuller social life to many patients.

The wide range of services now available in the nursing home provides care for the convalescent, the aged and the chronically ill and varies from minimal help to the ambulant patient to continuous nursing care for the bedridden patient. The maintenance of good standards of care, and fee scales within reach of all who need the boon of nursing home care but also providing a reasonable financial return to the home operators, should insure proper functioning of a needed facility which is a great community asset.

Many who have had occasion to avail themselves of such nursing home services will concur heartily in a recent editorial comment that "it is reasonable to suppose that there will always be a place for private nursing homes which offer good services at reasonable cost."[1] Studies verify the experience of many that the cost of care at home is far greater than the cost in nursing homes in most instances.

In the nationwide movement to provide better care for the chronically ill there is a growing awareness of the potential value of nursing homes as one solution to the problem. The individual physician and the county medical society, looked to for leadership and guidance in this movement, have a real opportunity here to cooperate in helping nursing homes meet adequately the increasing demands arising from an urgent need.

1. Nursing Homes, J. A. M. A. 146:562 (June 9) 1951.

Medical Postgraduate Education

The Regional Meeting of the American College of Physicians will be held at the George Washington Hotel in Jacksonville on Nov. 2-3, 1951. The states of Alabama, Georgia, South Carolina and Florida constitute the Region. The Regional Meeting of the College has not been held in Florida in four years.

There will be a number of outstanding lecturers, and the program is an attractive one. Members of the College are expected to attend. Any physician who is a member of his local medical society and is particularly interested in internal medicine is invited to attend.

* * *

The Committee on Medical Postgraduate Course of the Florida Medical Association will hold its fall meeting in October. Suggestions with reference to graduate education will be appreciated by the Committee. Please address Chairman, Committee on Medical Postgraduate Course, 1009 Stockton St., No. 6, Jacksonville 4.

Youth's Quest of Science

Come September, and for the nation's youth school days are here again. To school go the citizens of tomorrow. Among them are the scientists of tomorrow, and all of them will make use of science. In these perilous times, it is hard to conceive of a more constructive movement for the good of this country than a great national quest by the youth of America for knowledge in the sciences.

A million and more students in the high schools across the land, it is said, are eager to explore some phase of science. In their quest lies the hope of the future for a strong and prepared nation, for industrial progress, for a successful democracy, for peaceful living. The grass roots of science understanding, the foundation stone, is in these high school groups — in their science classes, in their science clubs and in their science scholarship contests.

Every physician, as well as every other man of science, has an opportunity to lend interest and encouragement to some embryo scientist. Perhaps it is the doctor's son, perhaps the child of the neighbor down the block, or perhaps a youthful patient whose idol the physician may be. To aid in kindling sparks of interest in any and all branches of science will help to fan into flame the latent genius of American youth. The benefits accruing to this nation and to the world from an accelerated science program in the schools should intrigue the imagination, especially of those who devote their lives to scientific pursuits, and could indeed turn the tide of history.

YOUR BLUE SHIELD

The First Six Months of 1951

Blue Shield of Florida, Inc. is finding a steadily increasing demand for its services. During the first six months of 1951, subscribers cared for by participating physicians and surgeons in Florida received $705,065.51 in benefits for 21,908 patients. In this total paid by the Blue Shield Plan to its physicians a few high points of usage stand out.

Two thousand one hundred sixty-five tonsillectomies were performed for which $77,200 was paid out. Among other items were 2,032 obstetrical patients cared for, for which $101,820 was paid in benefits. There were 1,548 appendectomies, 418 cystoscopies and 1,598 anesthesias performed. Physicians rendered 15,237 days of service to non-surgical patients for which they received $74,250.

It is impossible in this space to detail the various services throughout, but the above emphasizes the contribution which Blue Shield is making to the care of its subscribers. You, as a physician participating in this program are rendering the public a signal service.

STATE BOARD OF HEALTH

X-ray Shoe Fitting Machines

A study of 110 x-ray shoe fitting machines throughout the State by the Division of Industrial Hygiene of the Florida State Board of Health showed that 14 were producing more than the permissible amount of stray radiation. Of these, 8 have been rechecked after repair or adjustment and are now operating within permissible limits. The remaining 6 machines have still to be rechecked.

It is felt that production of excessive amounts of stray radiation will be avoided if operators of x-ray shoe fitting machines will observe the following procedures:

1. Customers should be limited to a maximum of three fittings each in any one day and twelve fittings in any one year.
2. Customers should not be allowed to operate the machine.
3. The number of x-ray fittings in any one store should be limited to fifty in any one day.
4. Automatic timer intervals should not exceed five seconds, and the machine should be adjusted so that the x-ray tube operates at not more than three milliamperes.
5. Machines should be kept in good repair, the metal filter in the floor of the foot opening should be protected from wear, and the intensity of stray radiation should be checked frequently.

Consideration is now being given to drawing up warning placards for attachment to all machines.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Box, Louise A., Tallahassee
Canning, Harold B., Wewahitchka
Clark, Clyde E., Lakeland
Gray, Harrien W., Miami Beach
Morgan, John M., Sanford
Nash, Selig R., Miami
Nayfield, Chester L., Monticello
Scheinberg, Peritz, Miami
Stern, Bernard, Miami Beach
Wiley, Charles R., Wildwood
Young, Robert W., Orlando

BIRTHS AND DEATHS

Births

Dr. and Mrs. Marcus B. Bergh of Orange Park announce the birth of a daughter, Donna Lynn, on July 1, 1951.

Dr. and Mrs. A. Judson Graves of Jacksonville announce the birth of a daughter on July 3, 1951.

Dr. and Mrs. Roscoe S. Maxwell of Punta Gorda announce the birth of a son, Douglas Huey, on July 10, 1951.

Dr. and Mrs. Benjamin F. Dickins of Fernandina announce the birth of a son, Benjamin Fisher, Jr., on August 1, 1951.

Deaths — Members

Nettles, Robbins, Ocala ..... July 21, 1951
Smiseth, Selmer P., St. Petersburg ..... July 21, 1951

Deaths — Other Doctors

Nelken, Bernard E., Baton Rouge, La..... Feb. 9, 1951
Bibby, Kenneth Adams, Winthrop Harbor, Ill. ..... Mar. 22, 1951
Sarjeant, George Evans (Col), Jacksonville ..... June 14, 1951

STATE NEWS ITEMS

The agenda for the World Medical Association meeting in Stockholm, Sweden, September 15-20 is nearly complete, according to Dr. Louis H. Bauer, secretary-general of the World Medical Association and president-elect of the A.M.A.

Presiding over the meeting will be Dr. Elmer L. Henderson, president of the W.M.A. and immediate past president of the A.M.A. Others from this country participating in the meeting include Margaret Natwick, executive assistant; Steven K. Herlitz, advertising manager for the W.M.A. Bulletin; Dr. R. L. Sensenich, member of the Council; and Dr. Austin Smith, editor of the A.M.A. Journal.

Public Relations conferences will be featured at the four medical district meetings in October. They are scheduled for 7:30 p.m. The moderator will be Dr. Eugene B. Maxwell, Chairman of the Association's Committee on Public Relations. Doctors' wives are invited and urged to attend these conferences.

Dr. William C. Roberts, Chairman of the Council, assisted by the other members of the Council, Drs. Arthur J. Butt, Benjamin A. Wilkinson, Eugene G. Peek, Jr., Eugene L. Jewett, Hugh G. Reaves, Leldon W. Martin, Adrian M. Sample and Donald W. Smith, is completing the details for the printed program which is to appear in your October Journal.

The meetings are scheduled as follows: Pensacola, October 22; Bradenton-Sarasota, October 24; Vero Beach, October 25; Orlando, October 26. All meetings will begin at 2:30 p.m.

Dr. Jack M. Waldrep of Ocala has taken a leave of absence from his practice in order to take postgraduate training in urology at Columbia University College of Physicians and Surgeons, New York.

Dr. John M. Morgan of Sanford announces the opening of his offices in the Arcade Building. Sanford is Dr. Morgan's home town.

Dr. Rudolph W. Heath, Hollywood, has been named a resident in psychiatry at Graylyn Hospital, Bowman-Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina.

Dr. Bricey M. Rhodes of Tallahassee has been elected president of the Florida State Board of Medical Examiners. Dr. Homer L. Pearson, Jr., of Miami was reelected secretary. Dr. Ralph Spires of DeFuniak Springs is the vice president.

Dr. Hubert A. Barge of Miami has been on an extended trip to the West which included a visit to the Mayo Clinic.

Dr. N. J. Dawkins of Vernon was recently honored by members of the community in tribute to his many years of service. The occasion was Dr. Dawkins' eightieth birthday.

Dr. Courtlandt D. Berry of Orlando has taken a year's leave of absence from his practice to teach obstetrics and gynecology at the University of Puerto Rico.

Dr. George F. Schmitt of Miami had an exhibit entitled "The Therapy of Heart Failure" at the A.M.A. meeting in Atlantic City, June 11-15.

Dr. W. D. Thorpe of Madison announces that Dr. C. K. Hayes, formerly of Starke, will be associated with him in the practice of medicine.

Dr. Sherman B. Forbes of Tampa, administrative medical consultant to the Florida Council for the Blind, assisted in a recent two-week course on the anatomy and physiology of the eye before a group of teachers preparing to teach children with impaired vision.

The Florida Obstetric and Gynecologic Society has scheduled its midyear meeting at the Soreno Hotel in St. Petersburg Dec. 1 and 2, according to Dr. Edward B. Pollard, chairman.

Dr. James C. Nowling of West Palm Beach has returned to his practice following a refresher course at the Harvard Medical School on clinical heart disease.

Dr. Graham W. King, Jr., Delray Beach, has taken a temporary leave of absence from his practice in order to do postgraduate work.

Dr. Martin Mangels, Jr. of Miami has been named medical director of Pan American World Airways' Latin American Division, succeeding the late Dr. John T. MacDonald.

The Committee on Medical Motion Pictures of the A.M.A. announces that a revised catalog of motion pictures is now available. Copies will be sent to the secretary of each county and state medical society. This catalog lists sixty-two 16 mm. films, most of which are at the professional level. Fourteen of these films are suitable for showing to lay groups. Eight new films have been added. Copies are available upon request from: Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

The 17th Annual Meeting of the American College of Chest Physicians was held at the Ambassador Hotel, Atlantic City, June 7 through 10, with a registration of 1040. On Saturday, June 9, at the administrative session, the following officers were elected for the coming year:

Drs. Chevalier L. Jackson, Philadelphia, President; Andrew L. Banyai, Milwaukee, President-Elect; Alvis E. Greer, Houston, First Vice-President; William A. Hudson, Detroit, Second Vice-President; Minas Joannides, Chicago, Treasurer; and Charles K. Petter, Waukegan, Illinois, Assistant Treasurer.

At the Convocation ceremony held on Saturday, June 9, 109 physicians received their Fellowship Certificates. Oral and written examinations for Fellowship in the College were given to 58 physicians on Thursday, June 7.

Dr. Clarence M. Sharp of Jacksonville serves as Governor of the College for the state of Florida. Dr. M. Jay Flipse of Miami serves as Regent of the College for District No. 5.

The annual Southeastern States Cancer Seminar will be held on November 28-30 at the San Juan Hotel in Orlando. There will be a ten man faculty from the Frances Delafield Hospital and Columbia University. Particular emphasis will be placed on newer methods of diagnosis and treatment. There will also be a panel on the treatment of pain and palliation.

COMPONENT SOCIETY NOTES

Dade

The Dade County Medical Association at the regular September meeting completes its third annual summer hospitality program for young men and women of Dade County who are studying or are planning to study medicine. Approximately 100 young people were guests at the Association meeting on July 3, August 7 and September 4.

Members of the Dade County Medical Association have been cooperating with the Miami Diabetes Association in a year-round detection campaign. Some 4,000 free diabetes tests have been made in their offices since the first of the year.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Members of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society met in Tallahassee on July 19 for their regular quarterly meeting. Included on the scientific program were a presentation and discussion of cases from the Leon County Tumor Clinic and a paper on scurvey. Participating on the program were Drs. Francis Holland, David McCulloch, Clarence W. Ketchum and Raney Oven, all of Tallahassee.

Pinellas

The Pinellas County Medical Society at its regular July meeting included on its scientific program "Carcinoma of the Pancreas" by Dr. Francis C. Hoare of Clearwater and "Review of the Seminar on Cardio-Vascular Disease" by Dr. Sidney Grau of St. Petersburg.

In accordance with custom, the Society did not meet in August. Regularly scheduled meetings will be resumed on September 10.

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As a Gastric Antacid

Alglyn®, dihydroxy aluminum aminoacetate, is the product of combining *aluminum* with the amino acid, *glycine*. It was developed by Krantz, of the University of Maryland, in co-operation with the research staff of the Brayten Pharmaceutical Company. The objective was to produce a nonsystemic gastric antacid *in tablet form* that would be consistently prompt and persistent in its action.

In this respect, the dehydrated forms of the aluminum hydroxide gels are known to vary considerably in *bulk* and in *rate of solution* in acid, depending on the drying method (mainly *temperature* and *rate of drying*), and also depending on the individual nature (concentration of the suspended material, its particle size, etc.) of the original liquid gel from which each dry form is made. Accordingly, there are differences in the activity of the various tablets available, depending on their origin. Differences are also found among various batches of tablets made from the same type gels *at different times*, depending on the age of the tablets and the conditions under which they are stored. These variables often made it necessary for the physician to compromise when using tablets; in order to give the patient the convenience of an easy-to-carry dosage form, some efficacy had to be sacrificed.

In contrast to tablets of the dehydrated hydroxides, *Alglyn tablets* were found to possess a uniform reaction rate, regardless of their shelf age. Laboratory evaluations have repeatedly shown that the reaction rate of Alglyn tablets compares favorably with that of liquid preparations of aluminum hydroxide.[1,2,3] The onset of action is somewhat more rapid for Alglyn than for dried aluminum hydroxide tablets. The difference in reaction rate is measurable by laboratory methods and is sometimes clinically detectable as well, as evidenced by the fact that patients frequently report that they get more consistently prompt relief from Alglyn tablets than from many other aluminum-antacid tablets. In ten minutes the pH is raised to approximately 3.9 and remains above 3.0 for two hours. Even when given in excess, however, Alglyn tablets cannot produce a pH higher than 4.5; neither cause alkalosis nor stimulate rebound secretion of acid.

Clinical experience shows that Alglyn tablets are eminently effective as gastric antacids, can be used effectively and safely for correcting hyperacidity whenever that is responsible for distress.[4,5] They are especially valuable in the treatment of patients who have peptic ulcer, and those who seem to be predisposed to ulcer—whenever both rapid and sustained control of gastric acidity is advisable, either for treatment or prophylaxis. In addition to their antacid effect, Alglyn tablets protect against corrosion from gastric juice in these ways:

1) curbing peptic activity by inactivating pepsin, independently of their effect on pH
2) by forming a coagulum with gastric secretions, resulting in the precipitation of a protective coating on the gastrointestinal mucosa

Altogether, these effects help to create and maintain a gastrointestinal environment that is conducive to uninterrupted ulcer healing.

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Alglyn tablets are supplied in bottles of 50 and 100 tablets. Each tablet contains 0.5 Gm. (7.7 grains) of dihydroxy aluminum aminoacetate. Brayten Pharmaceutical Company, Chattanooga 9, Tennessee.

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OBITUARIES

John Tremper Macdonald

Dr. John Tremper Macdonald of Miami died on April 3, 1951 at Doctors' Hospital in Coral Gables after an illness of several months. He was 66 years of age.

Born in Philadelphia in 1885, Dr. Macdonald was educated at the University of Pennsylvania and the Medico-Chirurgical College of Philadelphia. He pursued postgraduate studies at the University of Vienna and at the Sorbonne in Paris. Entering the United States Army in 1917 as a first lieutenant, he served as assistant divisional surgeon of the 78th Division and after the armistice was discharged with the rank of major.

Upon separation from the service, Dr. Macdonald located in Norristown, Pa., where he was a member of the surgical staffs of Montgomery General and Riverview hospitals. He also was resident physician at the Samaritan Hospital in Philadelphia. In 1934, he came to Miami, where he continued the practice of surgery. He was one of the co-founders of Doctors' Hospital in Coral Gables and was a member of the board of directors and a past chairman of the board at the time of his death. An ardent yachtsman, he was vice commodore of the Biscayne Bay Yacht Club in 1946, having acted as commodore during the war. His was a familiar figure on Biscayne Bay in his schooner, "Blue Stream."

Appointed Flight Surgeon for Pan American World Airways in 1938, he became medical director of that organization's Latin American Division in 1944. An authority on tropical diseases, he played a leading role in developing the medical safeguards that protect the health of its thousands of employees in Latin America; it was he who set up the elaborate medical testing program for Pan American pilots and flight crews.

Dr. Macdonald was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He was also a fellow of the American College of Surgeons.

Surviving are the widow, Mrs. Christiane C. Macdonald, and an adopted son, Robert Ian Macdonald, a World War II Navy veteran.

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Franklin Winbert Roush, Sr.

Dr. Franklin Winbert Roush, Sr., of St. Petersburg died in a local hospital on May 21, 1951. He was 73 years of age.

Born in 1877, Dr. Roush received his medical training at Miami Medical College in Cincinnati, Ohio, now the University of Cincinnati College of Medicine. He was awarded the degree of Doctor of Medicine in 1899. He interned at the United States National Military Hospital in Dayton, Ohio. After six years there, he became chief surgeon and held that position until 1918 when he enlisted in the Medical Corps in World War I.

In 1920, because of ill health, Dr. Roush came to St. Petersburg. Eight years later, he resumed the practice of internal medicine in that city. With the late Mrs. Edith E. Roush, he founded and built the St. Petersburg Country Day School. Locally, he was a member and deacon of the First Presbyterian Church, and was a former member of the Civitan Club. He was an honorary staff member of Mound Park and St. Anthony's hospitals. A Thirty-Second Degree Mason, he held membership in various Masonic Lodges in Dayton.

Dr. Roush was a member of the Pinellas County Medical Society, the Florida Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Julia A. Roush of St. Petersburg; two daughters, Mrs. Virginia d'Albert-Lake of Paris, France, and Mrs. Eleanor Quinton Smith of Charleston, W. Va.; one son, Dr. Franklin W. Roush, Jr., of St. Petersburg; three sisters, Miss Bess F. Roush of St. Petersburg, Mrs. Edward R. Sutherland of Hendersonville, N. C., and Mrs. Julia Esther Jackson of Los Angeles, Calif.; and seven grandchildren.

John Thomas Bowen

Dr. John Thomas Bowen of Clearwater died on March 16, 1951 at the Morton Plant Hospital in that city. He was 75 years of age.

Dr. Bowen was born at Five Points, Ala., in 1875. He received his academic degree from Emory University and his medical degree from the University of Pennsylvania School of Medicine. Later, he did postgraduate work at Emory and Harvard universities.

Dean of medical practitioners in central Pinellas County, Dr. Bowen engaged in the practice of internal medicine in Clearwater for forty years. As one of the first physicians in that area, he pioneered in the effort to obtain the hospital in which he died. He served on its staff for many years and was a former chief of staff. Prominent in the life of the community across the years, Dr. Bowen was a charter member of the Clearwater Rotary Club.

Most of his service in the first World War was spent in France, where he received a medal from the French government. He was also honored by the government of Greece for service rendered in that country.

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Dr. Bowen was a member of the Pinellas County Medical Society, the Florida Medical Association and the American Medical Association.

His widow, Mrs. Charlotte Stuart Bowen, survives him. Also surviving are one brother, Solon W. Bowen of Atlanta, Ga., and one sister, Mrs. Lucia Hamilton of Birmingham, Ala.

Robbins Nettles

Dr. Robbins Nettles of Ocala died on July 21, 1951 in that city. Death came on his sixty-third birthday as the result of cardiac disease.

Son of the late Mr. and Mrs. T. A. Nettles, Dr. Nettles was born on July 21, 1888 at Connell Springs, Ala. He was educated in his native state, receiving his premedical training at Howard College in Birmingham and the degree of Doctor of Medicine from the University of Alabama School of Medicine in 1912.

After serving in the Army Medical Corps in World War I, Dr. Nettles practiced medicine in Monroe County, Alabama, until 1926, when he came to Florida, locating in Clearwater. He practiced there until 1941, when he moved to Ocala, where he continued to engage in general practice.

Dr. Nettles was a Mason and a Shriner. He was active in the Kiwanis Club, having been a charter member of the Clearwater Kiwanis organization. His social fraternity was Pi Kappa Alpha and his medical fraternity, Phi Chi.

A member of the Marion County Medical Society, he was also a member of the Florida Medical Association and the American Medical Association.

Surviving are the widow and two daughters, Mrs. F. W. Brandon of Bristol, Va., and Mrs. David McKee of Atlanta, Ga.; two grandchildren; and four brothers, Samuel B. and Earl Nettles of Connell Springs, Ala., George Lee Nettles of Monroeville, Ala., and Circuit Judge Malcolm Nettles of Jasper, Ala.

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Head Pain as a Diagnostic Lead

Frequently the presence of head pain is overlooked. The physician learns of it only if he has made an effort to elicit the information. Since the etiology of the pain is the basis of rational management, the patient should be warned against taking medication before diagnosis is made.

Friedman[1] deplores the tendency to call any chronic recurring headache migraine. Careful history-taking and full physical and neurological examinations are essential for accurate diagnosis. A good starting point is a description of the headache — its character, laterality, frequency and intensity.[2]

The following chart gives briefly the primary diagnostic leads and treatment for the most common types of headache.

Etiology of Headache	Primary Diagnostic Data	Primary Therapy
Inflammatory e.g., Meningitis Abscess	Inflammation of intracranial structures; fever; leucocytosis; bacteriologic diag.	Specific: sulfonamides and antibiotics. Symptomatic: analgesics.
Tumor	Pain varies as spinal press. changes; skull X-ray.	Specific: surgery. Symptomatic, analgesics &/or hypnotics.
Sinusitis	Sinus congestion and infection; cloudy X-ray.	Specific: antibiotics and drainage. Symptomatic: analgesics.
Hypertensive	Hypertension present but pain not related to b. p. level; Dihydroergotamine. relieves pain.	General hypertension therapy; sedation. Symptomatic: analgesics.
Migraine & other vascular headaches	Headache: recurrent, intense, throbbing. No organic causation; migraine in family; patient: energetic, perfectionist. Visual prodromata; g-i. upset during headache.	To abort attack: oral ergotamine plus caffeine. General: adjustment to minimize nervous stress.

Data here tabulated is from: Wolf, G., Jr.,[3] and Friedman, A. P.[4]

Cecil[5] ranks vascular headaches, e.g., migraine and tension headaches, as the most commonly encountered of all. Because of their functional nature and usual recurrence at frequent intervals, they present a long-term therapeutic problem.

Therapy is conducted along two lines:

1) Psychotherapy to reduce the frequency of attacks. This consists mainly of advice on emotional adjustment to stressful situations and guidance toward a good balance between work and relaxation.

2) Treatment of the distressing attack to prevent the usual period of incapacitation. Many investigators have reported that ergotamine preparations are effective for relief of the acute migraine attack in 80% of cases.[1,6] *The drug is given immediately when an attack is approaching and dosage adjusted to the needs of the individual.*

1. Friedman, A. P. and von Storch, T.: 99th A.M.A. Session, June 1950. 2. Butler, S. and Hall, F.: M. Clin. N. Amer., p. 1439 (Sept.) 1949. 3. Wolf, G., Jr.: M. J. 54:25, 1951. 4. Friedman, A. P. and Conn, H. T.: Current Therapy, 1950, p. 563; Saunders Co., Phila. 5. Cecil, R. L.: A Textbook of Medicine, ed. 7, 1948, p. 1483; Saunders Co., Phila. 6. Horton, B. et al: Staff Meet. of Mayo Clinic 20:241, 1945.

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Because it is our aim to have one hundred per cent organization of auxiliaries to the county medical societies throughout Florida we are constantly asking about the attitude of the doctor's wife regarding our organization.

There has been a startling similarity of reasons for indifference and resistance, not only here, but throughout the nation. The same attitudes present the same problems everywhere. Is it that we are a clique? Os is that a cliché?

The trouble is not with the principles and aims of the Woman's Auxiliary to the American Medical Association with its component state and county auxiliaries. The trouble is with people.

There is always a nucleous of workers; always a spectator group; always those who pay their token dues and never attend; and, not to be forgotten, those who neither pay their dues nor attend.

Each year fresh officers make great plans to reduce the indifferent quotient and with starry eyes and remarkable optimism feel certain they will break through the impasse created by lack of interest in the unorganized areas and "carry the light." Yet, no matter how hard we work we are lucky if we convert three counties to our aims at the year's end. Why?

Because even the cooperation of an enlightened doctor cannot combat the complaint of a wife who brands the organization without purpose, dry and a waste of time.

Nor can he cope with the attitude that a "clique", a well acquainted clique, runs every-

thing; and not particularly well at that.

Nor could he in good conscience urge his wife to join a group of ladies who leave her stranded in a room full of people sipping her coffee with no one to talk to; at least no one she wants to talk to.

And, last, but not the weakest resistance, is the excuse that "her children come first."

We don't even approach the group whose husbands have not inspired them with any interest in his profession except that he make his own way.

So there you have it. These are but a few of the most recurrent obstacles we have to face. Hurdles we must span before the year is out, here and throughout the nation, and span them we must because our objective is not an esoteric problem.

If we yield the bulkhead of medicine to socialistic principles because of insufficient vigilance, whom can we blame? If a small state like Florida fails to rally in the face of danger and practice team-work to maintain our standards of medical integrity and independence, can we expect the people who are being taught by greater zealots than we that they can do better with controlled medicine, to rush to our aid?

No! If we have difficulty reaching the doctor and his wife to aid us in our efforts to stem this rising tide we cannot expect to reach the layman when he is being taught that he stands to gain if we lose.

What can we do? We must keep trying! No doctor abandons a patient who, through lack of understanding, fails to cooperate with his efforts to save him. He educates the patient through family and through friends. That is the method we must use. Our medical family is large and its friends are numerous and through them we may be able to adjust perspective.

If each of us takes a special interest in the "patient" we can make her know we are not unfriendly. We can interest her in the "dry medicine" long enough to see its purpose and create a desire to participate which will in itself expand the "cliques" which are well acquainted only because they have, of necessity, worked so long together. And in this participation will develop the realization that because "her children come first", she can by giving a little of herself now protect them from a sinister harm when she is no longer here or able to help them.

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From where I sit, I fail to see what makes a psychologist a better judge of humor than the rest of us. If a man gets a kick out of a joke that proves it was funny to him—doesn't it?

When psychologists try to set up a standard for a sense of humor for people they're getting too darn serious for me. It's the same thing when other "authorities" try to tell a man how he should practice his profession, or what kind of beverage he can drink. I'm partial to a glass of beer with meals myself—but I promise not to make any wisecracks if you prefer tea.

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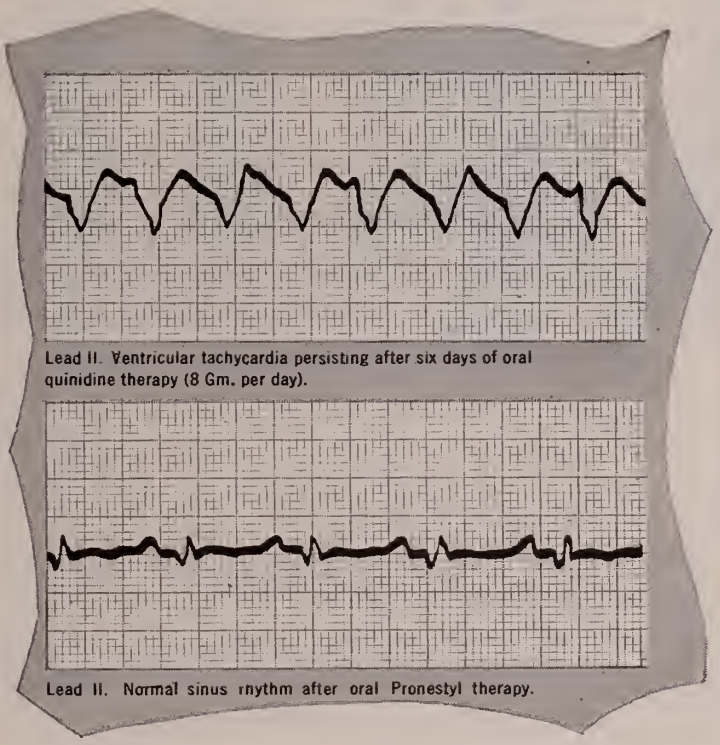
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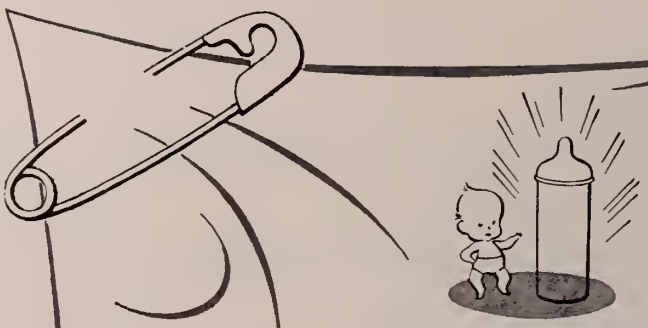
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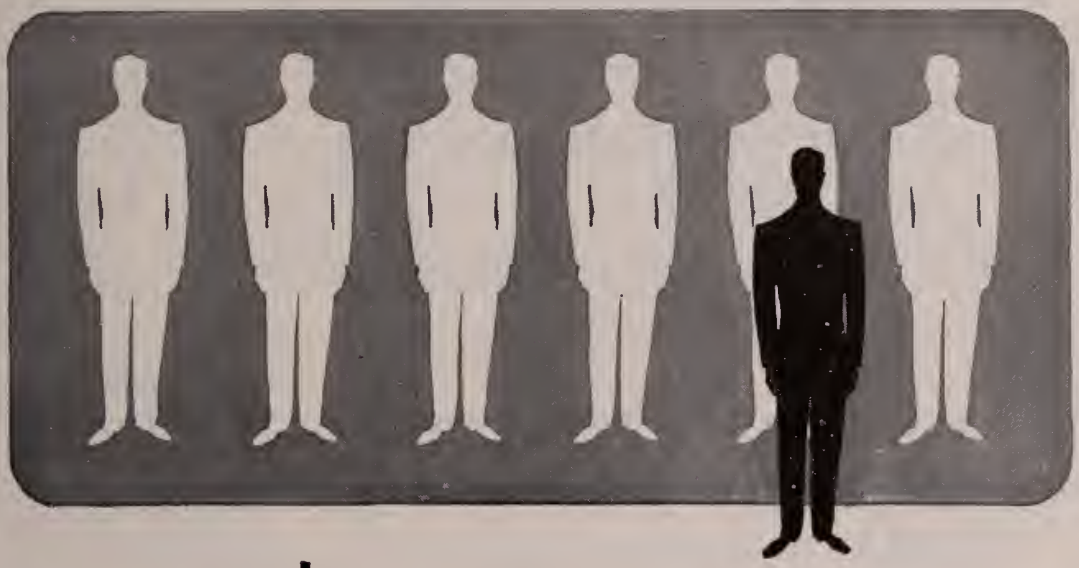
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1. Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.
2. Berberian, D. A., Dennis, E. W., and Pipkin, C. A.: *Am. Jour. Trop. Med.*, 30:613, Sept., 1950.

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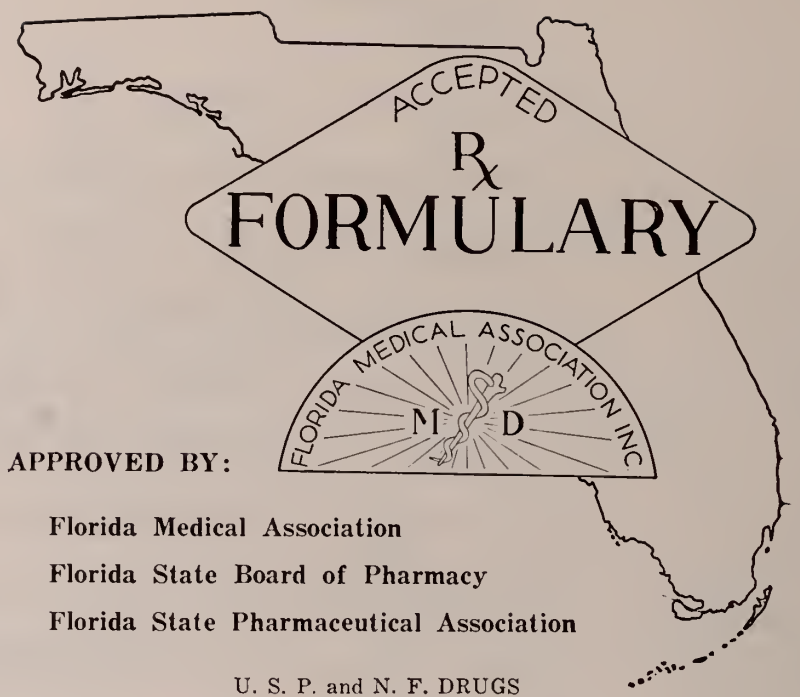
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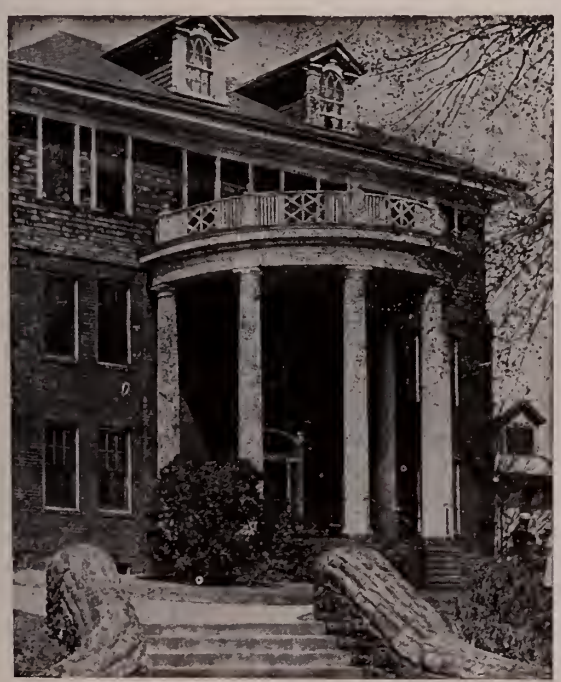
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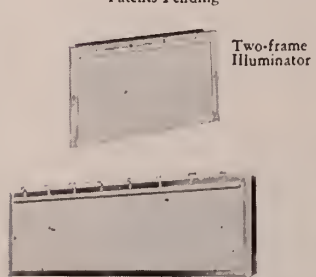
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '52
Medical Districts	William C. Roberts, Panama City	Council Chairman	
rthwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Pensacola, Oct. 22, '51
rtheast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Orlando, Oct. 26, '51
uthwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	B'denton-Sarasota, Oct 24, '51
utheast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Vero Beach, Oct. 25, '51
Specialty Societies			
y of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	Hollywood, Apr. 27, '52
Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	" "
siologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
, Am. Coll. Chest Phys	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
nd Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	" "
ial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	" "
gy & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
l Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
l & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	" "
dic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	" "
gical Society	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Lauderdale	" "
c Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	Orlando, Nov. 10-11, '51
gic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	Hollywood, Apr. 27, '52
gical Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
cal Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
—			
Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 10, '51
l Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando, Dec. 2, '51
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 27, '52
al Society, State	John I. Todd, D.D.S., Jacksonville	Tom Price, D.D.S., Miami	Jacksonville, Apr. 20-23, '52
ital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando, Dec. 3-4, '51
cal Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	Jacksonville, Nov. 25-27, '51
cal Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
es Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
naceutical Association, State	Mr. Euless Watford, Chipley	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-21, '52
c Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
rculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Pt. St. Joe	
an's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	Hollywood, Apr. 27-29, '52
n Medical Association	John W. Cline, San Francisco	Geo. F. Lull, Chicago	
A. Clinical Session	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Los Angeles, Dec. 4-7, '51
n Medical Association	Curtice Rosser, Dallas, Texas	Mr. C. P. Loranz, Birmingham	Dallas, Texas, Nov. 5-8, '51
a Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19, '52
, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 11-14, '52
ospital Conference	Edwin B. Peel, Atlanta	Mr. R. G. Ramsey, Jr., Memphis	Atlanta, Apr. 16-18, '52
stern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath, B, MacInnis, Columbia, S.C.	Augusta, Ga., Mar. 21-22, '52
stern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	Boca Raton, Apr. 2-5, '52
stern Surgical Congress	Joseph S. Stewart, Miami	B. T. Beasley, Atlanta	Atlanta, Mar. 10-13, '52
oast Clinical Society	Wesley Lake, Pass Christian, Miss.	C. D. Taylor, Pass Christian, Miss.	Gulfport, Miss., October, '51

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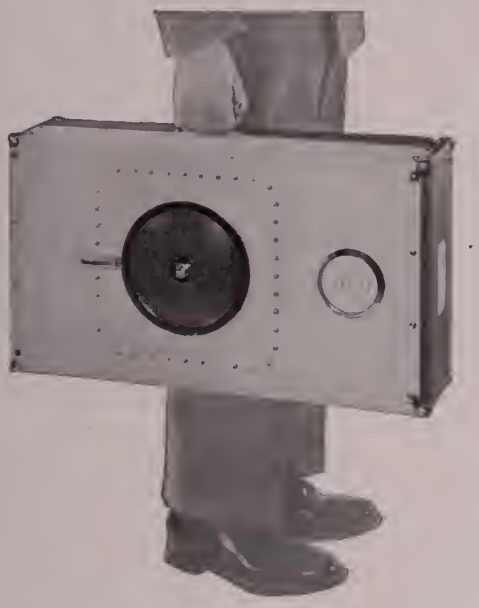
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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
					Total	Paid	
A	Bay	James M. Nixon, M.D. 825 Jenks Ave. Panama City	Harold E. Wager, M.D. Box 984 Panama City		21	100%	
	Escambia *Santa Rosa*	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	74	68	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	7	100%	A-1-52 Arthur J. Butt, M.D. Pensacola
	Jackson-Calhoun	Jasper B. Dowling, M.D. Route 1 Altha	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	15	
	Walton-Okaloosa	Arthur G. Williams, Jr., M.D. Valparaiso	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker-Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	14	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	John T. Benbow, M.D. Chattahoochee	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	Quarterly 7:30 P.M.	56	54	
	Suwannee	John N. Sims, Sr., M.D. Suwannee St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	7	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		3	100%	
	Taylor *Dixie-Lafayette*	Ralph J. Greene, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	227
B	Alachua *Bradford, Gilchrist, Union*	James M. McClamroch, M.D. 903 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 819 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	46	100%	
	Duval *Clay*	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	242	232	
	Marion *Levy*	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	28	26	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	100%	
	Putnam	Claude M. Knight, M.D. 121 Madison St. Palatka	James W. Brantley, M.D. Grandin	2nd Tuesday 6:00 P.M.	11	100%	
	St. Johns	Joseph A. Shelley, M.D. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	16	14	
	Brevard	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	20	19	
	Lake *Sumter*	H. Durham Young, Jr., M.D. 411 Lakeshore Dr. Leesburg	Lawton F. Douglass, M.D. Umatilla	1st Wednesday 7:30 P.M.	26	24	
	Orange *Osceola*	Fred Mathers, M.D. 314 American Bldg. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	148	100%	B-4-53 Eugene L. Jewett, M.D. Orlando
	Seminole	Thomas F. McDaniel, M.D. 315 Magnolia Ave. Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	14	100%	
	Volusia *Flagler*	Peter A. Drohomer, M.D. 210 Volusia Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	74	71	635
C	Hillsborough	R. Renfro Duke, M.D. 708 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	163	158	
	Manatee	Roderic O. Jones, M.D. 430 10th St., W. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	2nd Tuesday 8:30 P.M.	21	19	
	Pasco-Hernando-Citrus	Gail M. Osterhout, M.D. Box 296 Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	13	100%	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	Claude B. Wright, M.D. 214 First Fed. Bldg. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	183	181	
	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 203 Van Skike Bldg. Sarasota	2nd Tuesday 8:30 P.M.	42	41	
	DeSoto-Hardee-Highlands-Glades	Hubert W. Coleman, M.D. Box 98 Avon Park	Stanley K. Wallace, M.D. Sebring	2nd Tuesday 8:00 P.M.	26	24	
	Lee-Charlotte-Collier-Hendry	William H. Grace, M.D. 1925 McGregor Blvd. Ft. Myers	Angus D. Grace, M.D. 308 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	24	23	C-6-52 Leldon W. Martin, M.D. Sebring
	Polk	John W. Vaughn, M.D. Box 475 Lakeland	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	87	83	559
D	Indian River	Erasmus B. Hardee, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	
	Palm Beach	R. M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	Lorenzo James, M.D. 1300 N. Dixie Ave. West Palm Beach	3rd Monday 8:00 P.M.	103	96	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	St. Lucie-Okeechobee-Martin	Julian D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	16	14	
	Broward	M. Austin Loveioy, M.D. 409 Blount Bldg. Ft. Lauderdale	Thomas L. Roberts, Jr., M.D. 408 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	80	78	D-8-53 Donald W. Smith, M.D. Miami
	Dade	Jack Q. Cleveland, M.D. 167 Alcazar Ave. Coral Gables	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	575	522	
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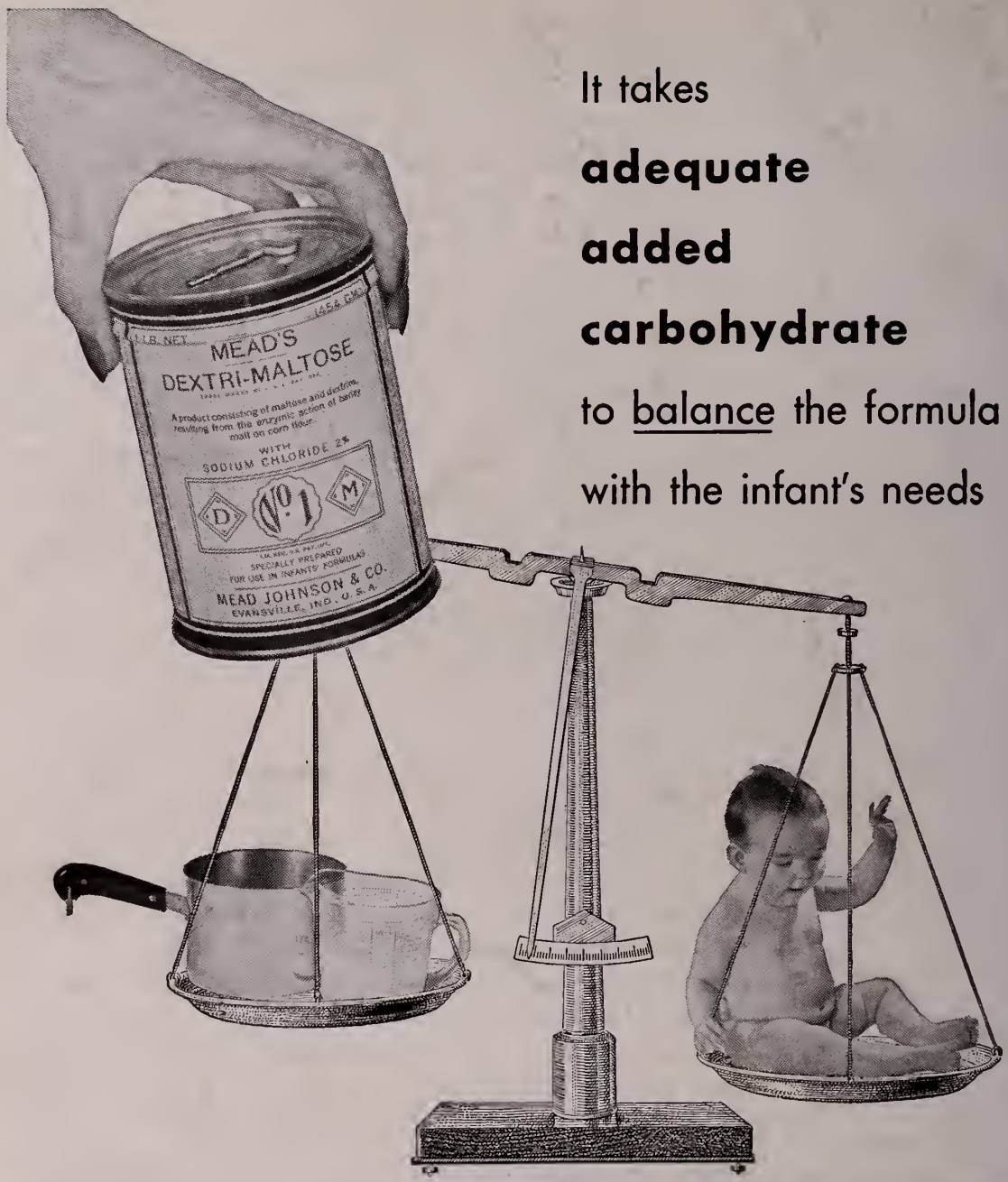
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Curtice Rosser

Medical Care in Poliomyelitis
Kenneth S. Landauer

Urinary Tract Infections
Grayson Carroll and Robert V. Brennan

October Anniversaries
An Editorial

Program Medical District Meetings
October 22-26, 1951

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*Cutting, W. C.: A Manual of Clinical Therapeutics, ed. 2, Philadelphia, W. B. Saunders & Co., 1948, p. 484.

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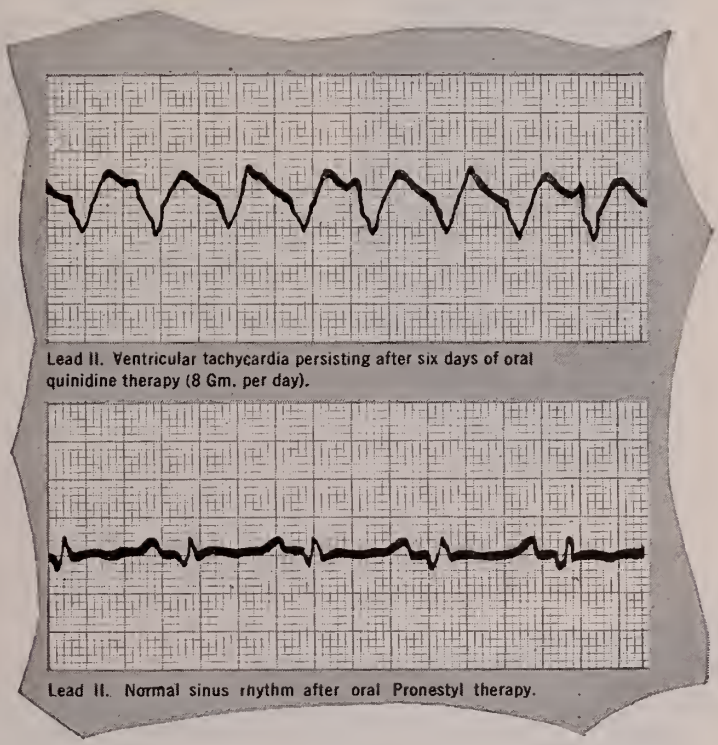
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Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida. October 23, 1924.

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1 Adams, C. H., and Cecil, R. L.: Ann. Int. Med. *33*:163, 1950.
2 Bayles, T. B.: Medical Forum, Mod. Med. (no. 24) *18*:86, 1950.
3 Gilbert, J. T., Jr., and Moore, F. H.: J. Kentucky State M. A. *48*:308, 1950.

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*Baumgartner, L.: Wider Horizons for Children; The Mid-century White House Conference and Children's Nutrition, J. Am. Dietet, A. 27:281 (Apr.) 1951.

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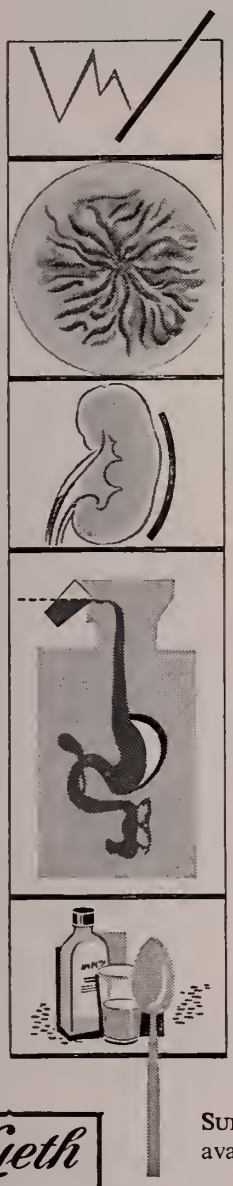
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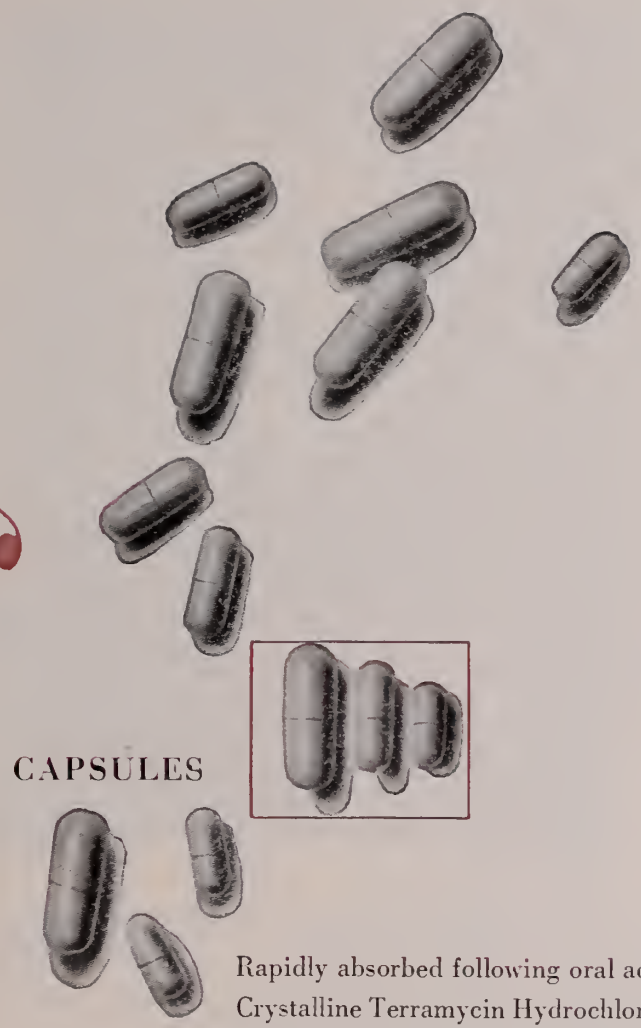
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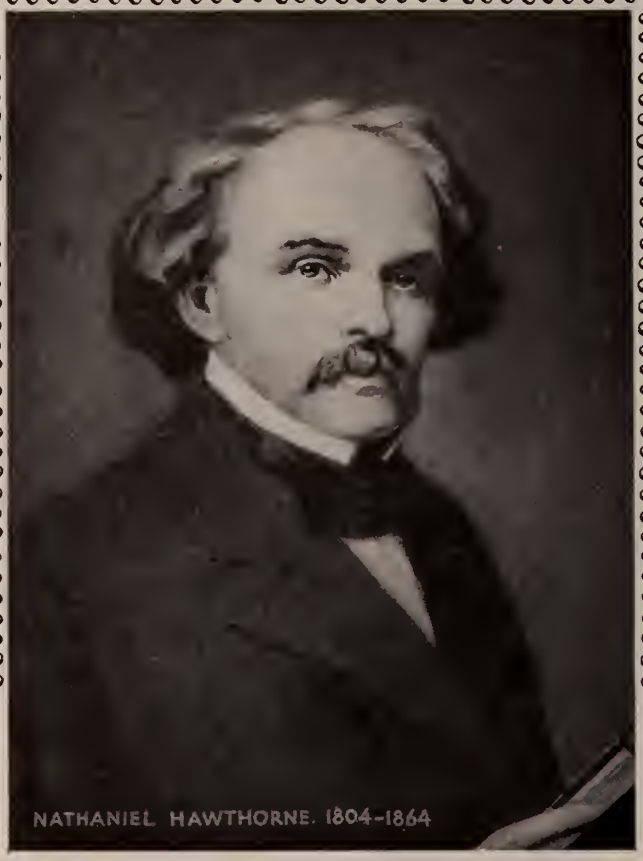
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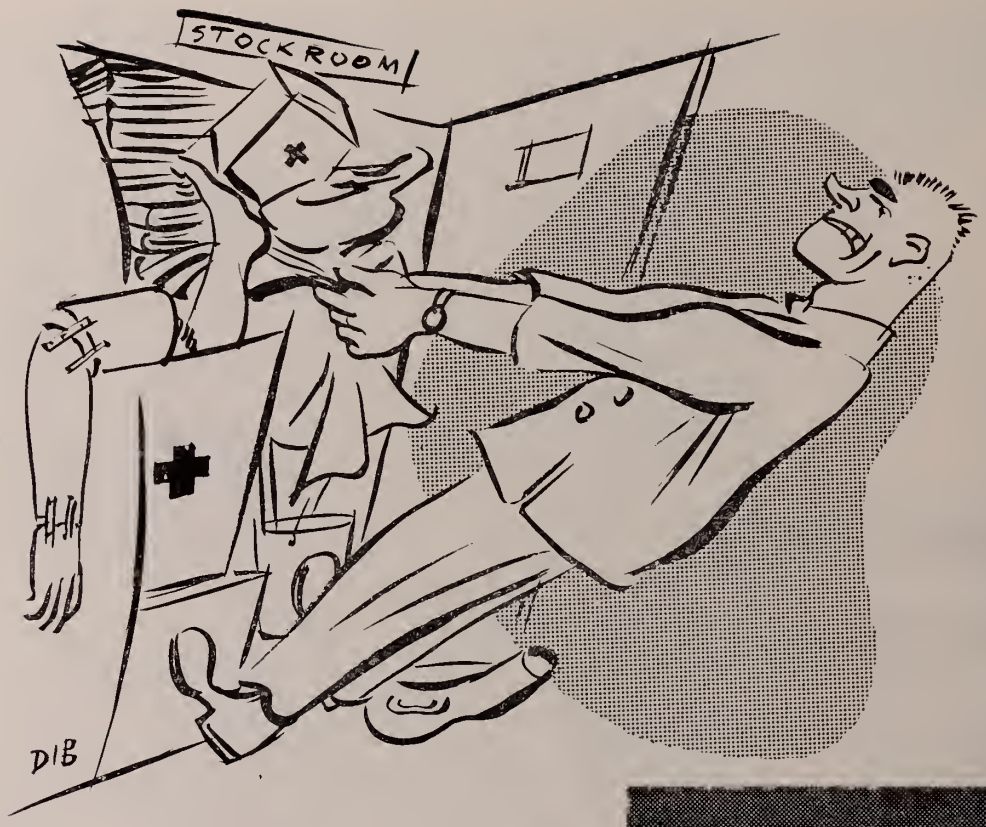
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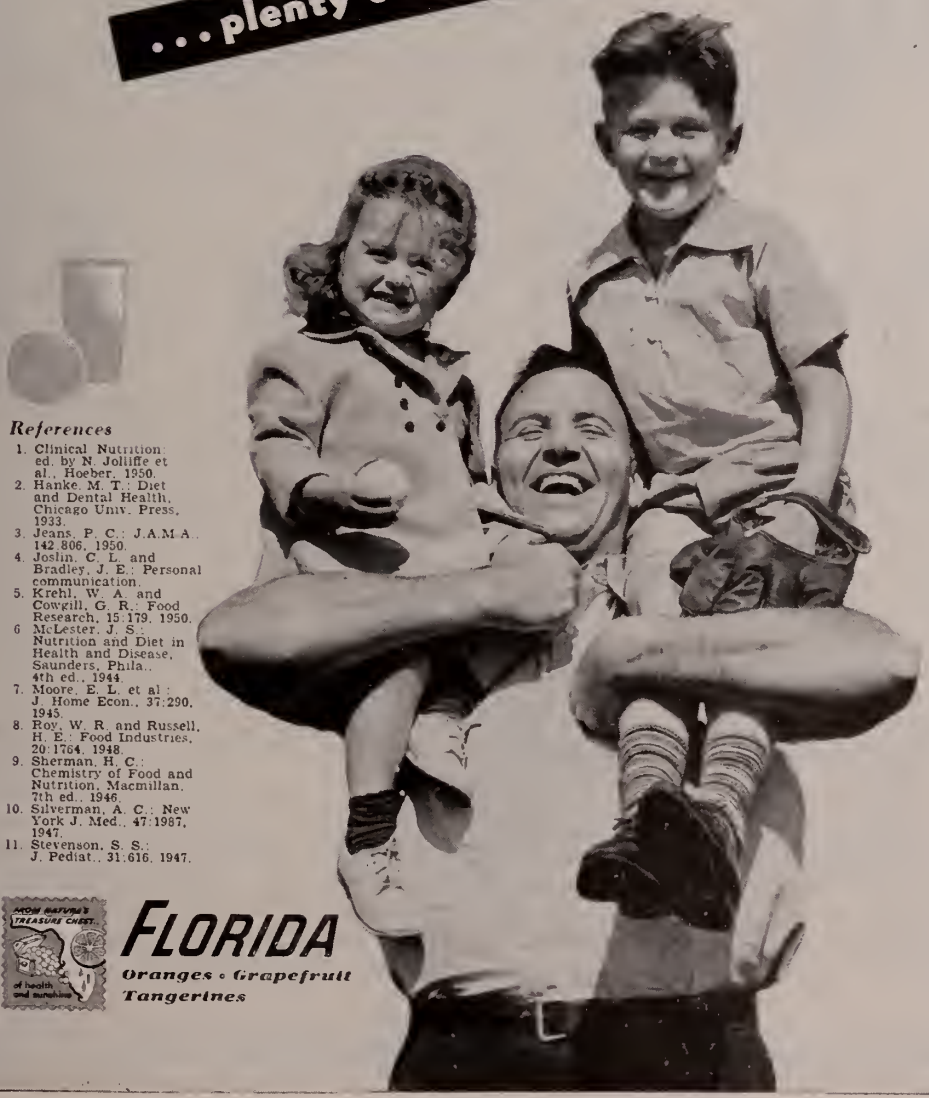
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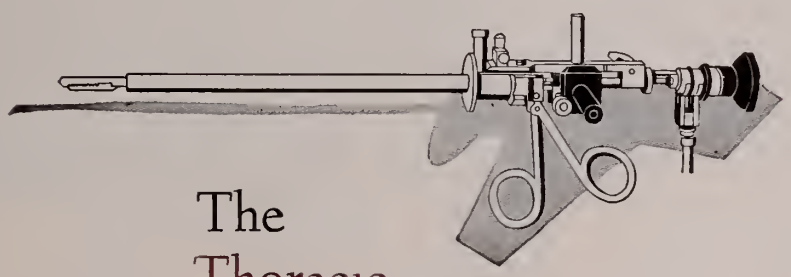
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXVIII Jacksonville, Florida, October, 1951 No. 4

Melanoma and Carcinoid of the Rectum

CURTICE ROSSER, M.D.
DALLAS, TEXAS

There is a definite reason for combining the discussion of melanoma and carcinoid of the rectum, and I hope to present convincing evidence that the hybrid union of these two rectal lesions is not unjustified. While both are rare, they occur sufficiently often to make it possible for any physician to encounter either unexpectedly, and this dramatic experience, as I can testify, will send him posthaste to the pathologist for aid and to the library for enlightenment. Both melanoma and carcinoid are believed to arise from embryologic neural cells. Both tumors are characterized grossly by color, black in the case of malignant melanoma and yellow when carcinoid occurs. Neither has been sufficiently well understood for general agreement concerning even the nomenclature, and both are at present purely surgical problems.

Melanoma

The pigment melanin is a complex iron-free chemical derived from tyrosine. It occurs normally in the choroid of the eye, in the skin and in the hair, but is difficult to isolate because it does not crystallize and is insoluble in fluids. It is most commonly encountered by the physician in the form of melanosis coli, a harmless mottled discoloration varying from light brown to brownish black, producing polyhedral markings which follow the pattern of the mucosal and submucosal vascular network. It results from the deposit of melanin pigment in the deeper layers of the mucous membrane as the result of the ingestion of anthracene drugs, especially cascara. This lesion apparently has no malignant potentialities and is entirely unrelated to malignant melanoma. The ingestion of lead and arsenic has also been reported to cause this phenomenon.

Melanoma is pigmented because melanoblastic cells commonly possess the property of withdrawing tyrosine from the blood stream and elaborating a complex chemical, chromogen, which is converted into the visible pigment through the activity of enzymes in the cytoplasm of the melanoma cell. It is interesting that in one third of the tumors the melanoblastic cells may be so actively reproductive, expending so much of their energy in cell division that the formation of melanin may not occur in the primary tumor even though it is almost always found in secondary deposits.

The malignant melanoma is the most virulent of all known tumors. According to Raven,[1] it is found in many groups of vertebrate animals including especially the ox, the horse, the dog, the cat and certain black-spotted fish. It is curious to record that grey horses are particularly affected and that here the lesion is commonly near or in the anorectum. The type cell of the tumor is the melanoblast, a dendritic cell which arises in the embryonic neural crest. It may be fusiform or cuboidal in outline, which explains the former tendency to classify the lesion as sarcoma or epithelial carcinoma, and long, slender, branching processes are always present. The amount of melanin present in the cells does not affect the malignant properties, and it is impossible to determine accurately the degree of malignancy by microscopic examination of the tumor. These melanoblasts have a tendency to separate from the main tumor. Small ones carried away in the blood or lymph streams can pass through larger lymph channels and finally terminate in the fine filtering system of the liver, lung, or bone, where even a single cell can divide and set up a metastatic focus. Larger clumps of cells are arrested in the regional nodes, but their arrest may occur long after distant invasion is present.

In the human the commonest sites, in the order of their frequency, are in the lower extremity,

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 23, 1951.
From the Department of Proctology, Southwestern Medical School of the University of Texas, Dallas, Texas.

head, neck, face, trunk and gastrointestinal tract; others reported are the mouth, esophagus and small intestine. The commonest site for tumors in the alimentary tract is in the anorectum, and more than 100 instances of tumors in this location have been reported. It is estimated that 0.25 per cent of all anorectal malignant neoplasms are melanomas.[2] Most of these occur in the skin of the anal canal where invasion of the rectum may occur secondarily, although a few have been proved to occur above the dentate line in the rectum. Tumors in the anus are frequently small as are those seen on the skin elsewhere, but those which have been found higher are usually larger and may be firm and elastic in texture or semifluctuant and partially polypoid.

If the tumor is not fixed and metastasis to distant regions, especially the lung, is not evidenced, the treatment, by exclusion, is radical surgical excision. Radiation therapy is of no value. Raven[1] explains this fact by stating that direct effects of radiation on the tumor are minimal with the usual doses and the intensity of the dose which is required to damage melanoblasts is greater than the skin tolerance dose. No reaction of the stroma is present because it has been replaced by malignant tissue; thus the deleterious action of the stroma on the cells following radiation is lost.

In 1948 a white man, aged 59, gave me a history of daily replacing a large protruding mass from the rectum for a period of four months. Bleeding had been confined to an occasional smear on the toilet tissue. On proctoscopic examination, it was seen that in addition to a fibroid papilla a large black prolapsing mass was present on the posterior and right wall of the rectum, which resembled a partially gangrenous internal hemorrhoid (fig. 1). It was pulpy in consistency, and a dark secretion was present, not blood. A biopsy was performed, which revealed that the tumor was a melanoma. Roentgen examination of the chest gave negative results, and no glands were palpated. In August 1948 a Miles combined abdominoperineal excision of the rectum was done, and the patient was given a permanent end colostomy. At the time, palpation of the abdominal viscera gave negative evidence. The patient's wounds healed rapidly, and for a period of two years he was well. At the end of that time, he began to evidence a pronounced anemia not affected by iron therapy. Roentgenograms of the chest demonstrated the presence of three nodules, apparently metastatic.



Fig. 1.—Black melanoma of the rectum prolapsed by straining.

Later metastasis to the brain occurred, and the patient died on Jan. 24, 1951.

In this case the rectal site of the lesion is unusual; in fact, Gabriel[3] stated that all anorectal melanomas originate in the anal skin and invade the rectum secondarily. So far as could be determined by clinical examination and by examination of the excised rectum and anus, this origin was not true in this instance although deposits of melanoblasts were found in tissues adjacent to the tumor (fig. 2). Moreover, there developed no evidence of invasion of the glands of the groin, which would be expected if the lesion were in the anus. Radical surgical measures were carried out because there was no other definitive alternative and no actual proof of metastasis existed.

It is well known that melanotic lesions of the mucosa, including those of the vulva, are in almost all instances fatal. On the other hand, it was stated at the Congress of Cancer in Paris in July 1950 that melanomas in very young persons do not metastasize and that there are lesions in adults which remain benign for long periods, are activated by trauma and may go through cycles of activity and quiescence. A prolapsing rectal lesion, of course, introduces the perilous element of daily trauma.

Carcinoid

Although the carcinoid was for many years associated in medical thinking primarily with the appendix, the first one described, but at the time unnamed, was in the small bowel. In 1867 Lang-

hans[4] reported a small polypoid tumor involving the submucosa and muscularis of the ileum, presenting an alveolar and infiltrating structure. In 1907 Oberndorfer[4] employed the term carcinoid to indicate a benign nature for the yellowish submucosal lesion, already differentiated from ordinary carcinoma and found especially in the appendix, the stomach and the colon. Ewing[4] stated that the origin of tumors of this type is from glands connected with the sympathetic nervous system. Because they stain deeply when impregnated with silver salts, Masson[5] suggested that they are tumors of the endocrine cells arising from the chromaffin system in the intestinal mucosa found below the columnar cells of the crypts of Lieberkühn and, therefore, termed them neurodrine or argentaffin cell tumors. Since they are often malignant and, in the colon and rectum often nonstaining, neurocrine may be a preferable term. Both gross examination and microscopic examination of the masses of spheroidal or polyhedral cells demonstrate a typical yellow tinge because of the lipoid content.



Fig. 2.—Deposit of melanoblasts found under perianal skin after radical removal of the rectum.

The benign type of carcinoid occurs in the appendix, usually at the distal end in contradistinction to cancer at the base, in 0.5 per cent of all appendixes removed surgically. Although it may be present at any age, it apparently has a tendency to occur in younger persons than do lesions in the remainder of the tract. Ewing[4] gave the average age for patients with appendical lesions as 25 years, while those discovered elsewhere in the bowel were in persons whose ages averaged 50 years. Although the lesion is present only one tenth as often in the ileum as in the appendix, it is still commoner in this area than is carcinoma, and it here begins to show its potentially malignant characteristics. Tumors of the small bowel are usually invasive, and many reports would indicate that one fourth of them involve the nodes and the liver, or both, when the lesions are discovered, indicating that metastasis may occur through the lymph or blood stream with equal facility.

Recognition of rectal carcinoids has occurred chiefly during the last decade. Ashworth and Wallace[6] in 1941 found 5 cases reported in the literature and added another. Stout[7] of the Laboratory of Surgical Pathology at Columbia University could find in 1942 only 6 instances of this rectal tumor previously reported in medical literature. Search of the material in his laboratory, supplemented by records of nearly 14,000 autopsies, resulted in the discovery of 6 additional cases of rectal carcinoid. None from the remainder of the colon were encountered in this series. Apparently, in none of these 6 cases were the lesions malignant, being yellowish submucous nodules, plaques or small polypoid masses; none of them gave any symptoms, and when excised locally, they did not recur. There exist, unquestionably, noninvasive and benign carcinoids in the rectum, and descriptions of these tumors in the literature may lull the surgeon into a sense of false security since carcinoids of the rectum, like those of the small bowel, possess a Jekyll-Hyde possibility of demonstrating highly malignant activity. This may occur in tumors of similar gross and microscopic appearance. Jackman[8] found 4 carcinoid nodules on routine proctoscopic examination, apparently alike, but 2 were invasive.

Table 1 records the further reports during the forties, evidencing that many of the tumors were found, as in Stout's series, by careful study of old material. Table 2 records the variations concerning invasiveness in the tumors which have been described. In 2 of the 3 instances reported by

Table 1. — Carcinoid of the Rectum (1941-49)

		Cases
1941	Previously reported	5
	Reported by Ashworth and Wallace (Pathology Department Baylor Hospital)	1
1942	Reported by Stout (Columbia University Laboratory of Surgical Pathology)	6
1946	Previously reported	14
	Reported by Dukes (Pathological Laboratory St. Marks Hospital)	9
1947	Described by Erlich and Hunter (Army Institute of Pathology)	10
	* * *	
1948	Previously reported	39
	Reported by Pearson and Fitzgerald (Mallory Institute of Pathology)	3
1949	Reported by Horn (University of Pennsylvania Laboratory of Surgical Pathology)	6
	Total reported	48

Table 2. — Carcinoid of the Rectum (1941-49)

Type of Lesion (when described)	Cases
Single submucous yellow nodules	28
Multiple submucous nodules	2
Polypoid nodules	3
Stenosing submucous tumors	2
Invasive tumors	6
Metastasis present	5

Pearson and Fitzgerald[9] of the Mallory Institute of Pathology, in 1948, invasion and metastasis, inoperable in nature, had occurred before the primary tumor was recognized.

My experience with the lesion began in 1934 when Mrs. B., a white woman aged 31, complained of the presence of blood in the stools and constipation, each of one year's duration. Proctoscopic examination revealed a small projecting plaque at a point 4 inches above the anus. A specimen for biopsy was taken, and the tumor was reported malignant. A Miles resection of the rectosigmoid and rectum was performed, and the patient recovered. The report on the tissue was as follows: "The resected portions revealed a polypoid mass measuring 0.7 cm. in diameter and composed of grayish red firm tissue. The mass was situated 10 cm. above the dentate line. The tissue cut with considerable resistance. Immediately adjacent to the mass was an ulcerated area of mucosa, measuring 2.5 by 1.5 cm. There was no induration of the intestinal wall at the base of the tumor or of the ulcer. Careful search revealed no enlarged lymph nodes.

"The microscopic sections showed the colon with intact glands containing an excess of mucus and lined by epithelium with small uniform nuclei, basally situated. A tumor in the muscular wall was composed of many small cells staining deep blue, with oval or elongated nuclei. These formed narrow bands and strands which appeared to anastomose widely with each other. The nuclei possessed finely granular chromatin. There was a tendency toward palisade arrangement, and in places pseudorosettes were formed. The tumor cells produced no secretion. Mitotic figures were absent. The stroma was composed of smooth muscle and loosely arranged connective tissue with a few small vessels. An occasional group of tumor cells extended into the mucosa. Also, there was extension into the tissue farthest from the lumen. In one region was an area of inflammation with granulation tissue, apparently the base of the ulcer. Tissue was not available for silver staining. The diagnosis was carcinoid tumor of the rectum."

In May of 1950 I examined a white school teacher aged 52 who, for two months, had observed some discomfort in the lower portion of the rectum, especially following bowel movement, flatulence and dysuria. A moderate-sized flat ulcer was found on the anterior wall of the rectum 5 cm. above the anus. There was induration of the lower portion of the rectum near the ulcer. Smears were negative for tubercle bacilli, and the biopsy from the ulcer demonstrated the presence of carcinoid cells. A Miles abdominoperineal resection was performed. The posterior wall of the vagina was near the tumor, but did not appear to be involved in the lesion, which was invasive, annular, and, except for the apparently traumatic or trophic ulcer, entirely submucosal. Nearby glands were involved, and a few flat, yellowish plaques were felt on the surface of the right lobe of the liver. The patient was able to leave the hospital, but after a period of two months from the time of the resection, a severe backache and dysuria developed, and a large recurrent mass in the perineum involving the vagina was found. This mass, including the posterior vaginal wall, was resected in September 1950, and several weeks later, radium needles were implanted in the granulating perineal wound with apparently favorable effect. Seven months after the patient's first symptoms, the liver suddenly became enlarged and reached the umbilicus. On November 11 the patient died from the hepatic involvement.

Two similar invasive and annular tumors with metastasis to the nodes and the liver have been reported in the literature. It is apparent that this patient had the lesion for some months before her

first symptoms as these pointed chiefly to the overlying rectal ulcer, probably a late development due to trophic changes and trauma. The fact that the lesion has this tendency to remain underneath the surface tissues tends to disguise its presence in early stages as is frequently the case when sarcoma involves the bowel. The efficiency of roentgen therapy is still to be appraised. It has been used following local resection of noninvasive nodules and polyps, but no actual information has been gained in this way.

Comment

Here are two bizarre and completely dissimilar neoplasms, never actually touching, but presenting curious and constant parallels in origin and behavior:

(1) Both are believed to come into existence from the migration of normal cells to a body surface.

(2) Because of the absence of early specific or localizing symptoms in either, the surgeon's recognition of melanomas in a malignant phase or those carcinoids which are malignant per se occurs almost invariably after metastasis is present.

(3) Metastasis in both occurs with equal facility through the lymph or blood channels and may involve any part of the body.

(4) Invaluable as the pathologist is in designating the neoplasm present, in neither can he predicate, from his examination of bits of the primary tumor, its malignant or nonmalignant properties and grading seems impossible.

(5) As collective information concerning these two neoplasms has slowly increased, the terms used to designate them have been discarded or revised constantly. In Bacon's most recent text,[10] for example, the tumor now known generally as melanoma is referred to as melanosarcoma, melanoepithelioma, malignant melanoma and melanoblastoma. Logically there is general dissatisfaction with Oberndorfer's term "carcinoid" for a tumor which, while benign in the appendix and on occasions in the remainder of the bowel, has violent carcinoma-like potentialities, and with Masson's designation of "argentaffin" for neoplasms which frequently (almost always in the rectum) fail to stain with silver salts. Stout,[7] incidentally, explained the failure of some tumor cells to blacken ammoniacal silver nitrate, a phenomenon always present in the argentaffin granules of the normal basigranular cells lying in the crypts of the intestinal wall, as due to the absence of a chemical "enteramin" in the cells. Because of these obvious objections to "carcinoid" and "argentaffin" there is a present trend to adopt Masson's alternate designation "neurocrine tumors."

(6) Treatment of melanoma in the malignant phase, which, from discussion at the Congress on Cancer in Paris last July, apparently is induced by maturity of the person combined with trauma, and of the malignant type of carcinoids, is unsatisfactory. The efficacy of roentgen rays has been disproved in melanoma and is unproved in carcinoid. The surgeon is left with only his scalpel and a prayer in either case.

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Medical Arts Building.

MEDICAL DISTRICT MEETINGS

Pensacola, Oct. 22, 1951
Bradenton-Sarasota, Oct. 24, 1951
Vero Beach, Oct. 25, 1951
Orlando, Oct. 26, 1951

Problems of Medical Care in Poliomyelitis

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NEW YORK

Until we physicians eventually conquer poliomyelitis by the development and application of safe practical methods to prevent paralysis and death, we seem to be facing the prospect of increasing epidemic incidence. A review of some important problems of medical care in polio is worth while.

With a rising age incidence and severity of the disease directly correlated with it, we are seeing many more serious cases. An illustration of the latter fact is the rapidly growing number of chronic respirator cases in the nation. I thought that you might be interested in what the picture is nationally and what we are trying to do about it, since these aspects have direct clinical interest. This approach may also serve to point out a typical facet of the activity of the National Foundation medical department in its efforts to help clinicians improve care for polio patients.

A survey of chronic respirator cases in the nation in November 1950 disclosed:

1. Five hundred and eighty-three chronic respirator cases, of which 60 per cent were cases from 1950 and 40 per cent had required respirators one or more years; this number represents a 30 per cent increase over the preceding year, despite one-fourth fewer cases of polio.
2. The cost to the National Foundation, paying for care for over 80 per cent of all cases, was at a rate of about $8,000 per day or between two and three million dollars per year.

These cases were scattered over the country, isolated individually for the most part, in 135 different hospitals, the patients often requiring expensive individual nursing around the clock.

It is interesting clinically and epidemiologically that two thirds of these patients were over 15 years of age, one half over 20, and one third over 25. Also, up to 10 years of age, there were twice as many males and over 20 years of age, 15 per cent more females.

We clinicians have long realized the need for more knowledge about the basic physiologic, psychologic and anatomic disturbances in patients with bulbar and spinobulbar poliomyelitis, especially those with breathing difficulties, the dreaded complication of poliomyelitis that kills so many. We have been relatively helpless in many of these situations; without simple practical clinical tools for evaluation of these disturbances, we have lacked accurate criteria for rational therapy. As a consequence it is believed that many still die who might be saved, and many survive to become unnecessarily long term prisoners of respirators. The rapidity with which patients become psychologically, physiologically and then anatomically "fixed" in respirators calls for early expert care if they are not to become chronically dependent on respirators.

We can figure from experience that during an epidemic, about 20 per cent to 30 per cent of cases will be bulbar or spinobulbar cases, and that about half of these cases will require the use of respirators for varying periods. It is our job, of course, to make equipment available to you. Respirators, tank and chest, and rocking beds from six pools are shipped in by air, when necessary, to the point of need to supplement local equipment.

Although the mortality rate appears to be dropping somewhat, probably because of the availability of more hospitals, equipment and nursing personnel for care in recent years, it is still relatively high, and it accounts for the death of about one fourth to one half of our critical cases with breathing difficulty. Advances in knowledge are necessary to help us further reduce deaths. It is already being demonstrated that newer knowledge and technics in care applied early in the course of respiratory difficulty will help us get more patients out of respirators earlier than is now the case.

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Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 24, 1951.

National Conferences

Consideration of what the National Foundation has been doing about these problems suggests:

First, we have sponsored a series of four national conferences of clinicians and basic science researchers, on the problems of care of bulbar and respirator patients, and these have served to stimulate thinking and investigation and a teamwork approach. They have brought about a critical re-examination of existing knowledge and a definition of the remaining problems to be solved.

The clinician has had to analyze his own rationale for treatment methods in the light of facts from the researcher, and this necessity has stimulated the basic scientist to adapt research methods, technics and equipment for practical clinical use. Together they are now working to study and analyze physiologic disturbances and to correlate them with practically useful clinical criteria as guides for the evaluation and management of patients. Interest in both diagnostic and therapeutic equipment problems is resulting in the development of a number of new devices, and improvements in existing ones.

Clinical Investigation Centers

It became obvious that the National Foundation must establish and support special centers for purposes of patient care, evaluation, clinical investigation and teaching, in university medical centers where patients could be grouped for care and studied by a team of both clinical and basic science interests, and where special equipment and personnel could be concentrated for the purpose.

Two such centers have already been established to serve the following purposes:

1. To conduct experimental and demonstration care programs, and provide teaching and training for professional personnel.
2. To carry out patient evaluation and clinical investigation, combining clinical and basic science disciplines in the study of patients.
3. To evaluate critically the diagnostic and therapeutic equipment and technics, measuring their physiologic efficiency, recommending modifications for improvements, and developing new equipment.
4. To serve local hospitals, by admitting selected cases for evaluation, investigation and trial therapy, and to provide consultative and assistive services to physicians in local hospitals, especially during epidemics of polio, when requested.

In addition to these clinical investigation centers, the National Foundation is encouraging the grouping of respirator patients in good hospitals where care personnel can be trained and special equipment can best be provided to aid them. The advantages of group care have been amply demonstrated.

It is of interest to point out that respiratory and cardiovascular physiologists have made tremendous progress in the last few years, and there are many research devices and technics available to study these problems which we have scarcely begun to apply to patients. In our program to support their clinical application and to stimulate and support further research in these problems, which are not alone peculiar to poliomyelitis, we are advancing clinical knowledge and skills important in many other fields as well.

Overhospitalization

Turning now to other problems, I should like to present one perplexing question for the solution of which we must turn to the practicing physician caring for polio patients, namely, the problem of overhospitalization. Although no records exist for accurate comparison, it is obvious that proportionately many more patients in whom polio is diagnosed or even suspected are being hospitalized today than ever before. There are a number of contributing factors:

1. Compared to five years ago, there are today almost four times the number of hospitals, well distributed over the nation and better equipped and staffed, now accepting acute cases of polio. It is thus easier to obtain admission of patients.
2. There is little or no cost deterrent; if the patient cannot pay, his chapter will.
3. There is greater public and professional awareness of symptoms and signs, bringing attention to many cases formerly unrecognized, especially those of abortive and nonparalytic types.
4. The National Foundation has long encouraged early hospitalization for early treatment, to save lives and minimize deformities. We necessarily rely on the physician's clinical discretion to care for 'suspects' and 'abortives' in the home.
5. There is an unwarranted persisting "pesthouse" attitude about polio. Many of the public and some of the profession still believe that persons with polio should be hos-

pitalized to protect the remainder of the family and community. We know that hospitalization in the manifest case to control spread is futile. By the time a case is suspected or recognized, the remaining members of the family and many other intimate contacts are already excreting polio virus, most of them having silent infections. Therein also lies the futility of quarantine.

6. Many physicians prefer not to care for patients with polio and even refer all suspects to a hospital for diagnosis and care by a polio team. In many cases, diagnosis and care can be given in the home with the aid of a consultant when needed. Spinal taps are not usually required for diagnosis.

7. Hospitals should establish admission diagnostic screening clinics, and admit only those patients for whom close observation or care is needed.

8. Many patients, of course, are hospitalized immediately because of poor home situations or inconvenient distance from physician or consultant, or from the hospital in case emergencies develop; or because public health or visiting nurse services or physical therapy is not available in or near the home.

Altogether the trend has been to recognize more cases, and to admit the great majority to hospitals for diagnosis as well as for care, often to the disadvantage of the patient, the hospital, and the agency rendering assistance.

The net result of this trend, plus the record high incidence of the last three years in which more cases have been reported than in the previous ten years, together with the great increase in hospital costs, is that the National Foundation for Infantile Paralysis has wound up each of the last three years in debt to the next March of Dimes for hospital bills. Almost five million dollars of this year's funds have gone to pay last year's bills, and unless we have an unexpectedly light epidemic year, we shall run out of funds long before the job is done this year.

It has been shown that in many cases the disease can be diagnosed and the patient cared for adequately at home, thus conserving hospital facilities and personnel for the more critically ill or seriously involved, and also conserving funds. The physician should become more familiar with the use of the community's resources to help the family care for patients at home.

In some communities where good public health leadership and services exist, proper planning, organization and use of medical consultants, public health nurses and visiting physical therapists have made good home care possible.

This is especially important because there are a number of disadvantages to hospital care. First, there is the psychic trauma of separation from family and home security and isolation in a strange place. Second, the relatively less adequate attention to patient comfort and ordinary needs in the crowded polio ward of the average hospital during epidemic load stress is a handicap. Staff shortages are increasing. Third, transportation of the patient with acute polio, with attendant trauma and fatigue, is clinically recognized as an additional hazard.

A third big problem is that of unnecessarily prolonged hospitalization. Through hospital polio census surveys conducted during the last year, it has become obvious that if we could but reduce the length of hospital stay of nonparalytic patients and those with but minor involvement, roughly half the cases, we could effect a great economy of hospital space and personnel and could free large funds for the more useful purposes of caring for and rehabilitating the paralytic patients.

To accomplish this objective requires the physician's cooperation in discharging those patients early who may be followed up and treated as outpatients. Hospital bed and board are expensive, and doubly so when unnecessary for there is waste of space, facilities and personnel as well as funds.

When the provision of more home and outpatient follow-up and treatment services are needed in order to relieve the epidemic hospital load, the National Foundation makes epidemic aid grants to health departments or hospitals so that these services may be established during the emergency.

When the home situation is adequate, the diagnostic and therapeutic consultation services and auxiliary services for continued follow-up and treatment, consisting principally of public health nursing supervision and physical therapy under orthopedic direction, are available, the physician is urged then to arrange care for many at home who are now hospitalized, and to discharge earlier the many patients who could be as well cared for at home.

Personnel

War time shortages again intensify a fourth big medical care problem we face. Along with equipment and epidemic aid funds, the National Foundation supplies nurses, physical therapists and resident physicians to help physicians and hospitals meet epidemic emergencies in communities throughout the nation.

Personnel are again in short supply, and it is essential that we employ our professional assistants to the best possible advantage, and that we use more practical nurses, nurses aides and trained volunteers if we are to meet the epidemic needs of the country this year.

Known Facts About Polio

Realizing that there are few physicians today without either a clinical or a personal interest in polio, I thought that in closing I would present a brief summary of known facts about polio and of our progress toward the prevention of paralytic polio. I believe we will all agree that polio is the most serious of our remaining uncontrollable communicable diseases. We can summarize its natural history by saying that:

1. Polio is a common virus infection of human beings, without any evident extrahuman reservoir.
2. Polio may be caused by any of three known immunologically different types of polio virus.
3. All evidence points to transmission of polio virus by close person to person contact of the kind that occurs between members of a household, and there is no reliable evidence of transmission to humans by insects, water, food or sewage. When polio afflicts one member of a household, the other members and close personal associates of the family are commonly found to be infected with the virus.
4. It is believed that the virus gains entrance to the digestive tract through the nose and mouth and, in those relatively few in whom manifest disease is to develop, travels directly up nerve pathways to invade the central nervous system.
5. The elapsed time from infection to onset of symptoms — the incubation period — may be from three to thirty-five days, usually seven to fourteen.
6. The sources of infection are considered to be the secretions of the pharynx and the excretions of the bowel from infected persons, including patients; although there is no evidence involving flies or sewage in the spread of virus to humans, these must be regarded still as potential sources of infection. It is believed that the infected person is most likely to transmit the virus during the latter part of the incubation period and for a few days after the onset of symptoms, although stool excretion of the virus begins shortly after infection and may continue for several weeks thereafter.
7. Polio produces silent infection with resultant immunity in the many; manifest disease in the few, with a broad clinical spectrum from minor illness to rapidly paralytic death. Recent surveys indicate that about 80 per cent of the population over 15 years of age possess antibodies to one or more of the three known types of polio virus.
8. Polio is an ancient disease and has emerged only in more modern times in serious epidemic and paralytic form and paradoxically in those countries with the highest material standards of living.
9. Peak incidence is now in the 5 to 9 year age group, and 25 per cent of cases are now over 15 years of age. The epidemiologist indicates that this is due to deferred exposure. The clinician observes that this carries penalties, as is true with other infections commonly occurring in infancy and childhood, for the older the patient, the more severe the consequences. Provided with antibodies at birth from an immune mother, and exposed to infection during the period of passive protection, the infant can apparently acquire active lasting immunity without serious risk of paralytic disease. It is believed that we have in some way disturbed this natural process, deferring exposure until persons are more susceptible to paralytic disease, and that epidemics of manifest disease are replacing the pattern of polio as an endemic disease with milder characteristics.

Vaccine

Among the essential steps toward the development of a vaccine preventive were, first, the collection and identification or classification immunologically of all possible types of virus that can cause polio. This tremendous typing job is just about completed, and indications are that all known strains fall into three immunologically distinct groups. A vaccine will necessarily contain representatives of each of these three groups. The second step was cultivation of the virus outside the living primate, to obtain it in more purified form and in practical quantities for vaccine production. Wonderful progress is being made here through growth of virus in tissue cultures. In addition, the latter technic has speeded up the job of virus-typing, and the titering of antibody in immune serums, both of which have been most costly and laborious procedures. Third, demonstration of the efficacy of polio vaccines in experimental animals was acomplished, as you know, though much additional work still needs to be done.

The situation at this time is that we think we will be able to prepare a combined vaccine against all known polio viruses, and that it should work with experimental animals. If this expectation proves to be true, there are some other problems remaining to be solved, such as how to try the vaccine out with human beings, how to test duration of effect, size and number of doses which would be needed, how to get the great quantities of viruses of the different types needed to make vaccine for all who should have it, and, especially important, how to determine among the total population the susceptible persons who should be innoculated. The question of the relative values of effectiveness of inactivated versus live virus vaccines, the question of adjuvants to enhance effects, the possibility of producing modified or attenuated virus strains, minimizing virulence and pathogenicity, with preservation of immunizing potency, these and many other problems will still need answers. Though we are optimistic, it is obvious that we shall not overnight have a safe effective vaccine with which to control polio epidemics.

It is not impossible that a combination will prove to be most desirable, a combination of both passive and active immunizing agents, or perhaps a chemoprophylactic agent with modified live virus vaccine. Scientists are also considering the possibility of the control of polio through the prophylactic administration of a polio antibody-rich serum, such as gamma-globulin. Before large scale field trials can be made to test it, some questions to be answered are: (1) What concentration of antibodies is required to protect humans against paralytic polio; (2) How long will such passive antibodies remain effective in the human; (3) Will the introduction of such passive antibodies prevent the benign infection of the individual and the consequent development of lasting active immunity; (4) How large a field trial would be necessary to produce significant results and under what conditions? Many brilliant minds in well equipped laboratories are collaborating in a well supported and coordinated effort to get us the answers to these and other related problems.

As to the possibility for the discovery of a curative agent to treat polio, when it has become clinically manifest, there seems to be little reason for hope. Once the virus is within nerve cells producing clinical symptoms and signs of polio, it would seem impossible to find an agent so selective in action that, introduced intracellularly, it would not also injure the cell itself while destroying the virus. Nevertheless, explorations are being made of this possibility also.

For lack of a quick and specific diagnostic test for the presence of virus, or for antibodies to detect immunity, the health officer and the clinician are severely handicapped. There seems now, however, to be good reason for optimism on this count, if current work develops as we all hope for.

Finally, I should like to say that this year we in the medical department of the National Foundation will need your help, understanding and cooperation more than ever before, to be able to meet our obligations and fulfil our public trust.

120 Broadway.

MEDICAL DISTRICT MEETINGS

Pensacola, Oct. 22, 1951 **Vero Beach, Oct. 25, 1951**

Bradenton-Sarasota, Oct. 24, 1951 **Orlando, Oct. 26, 1951.**

Antibiotics in the Treatment of Urinary Tract Infections

Grayson Carroll, M.D.*
and
Robert V. Brennan, M.D.
st. louis

Bacteria causing infection have been one of the major foes of man. Ever since Pasteur discovered these micro-organisms as the causative factor in so many maladies, science has set about to study and combat this foe.

Great progress has been made in this war in the last decade by the introduction of new chemotherapeutic agents and antibiotics. These scientific findings have prolonged and saved more lives than the atomic bomb has destroyed life to date. In experimental work following the Bikini A-bomb blast, antibiotics reduced mortality in radiation-exposed goats and dogs, and even in human radiation sickness. Hammond and Miller[1] found bacteremia present during the period of highest mortality. The mucosa of the bowel, which is the reservoir for bacteria, was found to be highly susceptible to injury from ionizing radiations.

These drugs have reduced tremendously the incidence of pneumonia, gonorrhea, typhoid and typhus fever, mountain spotted fever and nose and throat infections, as well as urinary infections. Hospitals are no longer crowded with patients desperately ill with pneumonia and children undergoing mastoid operations. Complications of pregnancy have been greatly reduced.

Antibiotics have reduced the operative mortality and have made extensive operations possible, thus making it feasible to eradicate extensive cancers heretofore considered hopeless. These powerful drugs should not be administered indiscriminately, however, and without knowledge of their limitations, as well as their usefulness.

The theme of my discussion may be stated briefly:

(1) No one drug will inhibit all organisms causing infection.

(2) There must be selection of the proper drug for each type of infection.

(3) To make the proper choice, the infecting organism must first be identified.

(4) A knowledge of the drug most likely to inhibit a given organism is necessary.

(5) If this drug, upon trial, does not relieve the infection, then sensitivity tests should be made either by the serial dilution method or by the disk method.

When a patient has an infection, a gram stain of the centrifuged urine made in the office will identify the presence of a coccus or a bacillus. Penicillin can then be prescribed for the coccus, and one of the other drugs, such as mandelamine or gantrisin, can be utilized if it is a bacillus. Should this therapy not clear the infection in two or three days, a specimen of urine should be collected for culture. A catheterized specimen is preferable in the female; in the male, the urine is collected in a test tube as it is passed through the urinary stream.

Every physician of today should see to it that he has laboratory facilities, either directly or by mail. Infection plays too important a role and causes too serious complications to treat it in a haphazard fashion and not take advantage of the more recent scientific developments.

Although there are many different species of organisms found in infected urine, we have chosen to discuss the nine most commonly isolated. These

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are enumerated with their relative frequency of occurrence as follows:

(1)	Escherichia coli	26 per cent
(2)	Pseudomonas aeruginosa	15 per cent
(3)	Aerobacter aerogenes	14 per cent
(4)	Proteus vulgaris	13 per cent
(5)	Escherichia intermediate	9 per cent
(6)	Staphylococcus	9 per cent
(7)	Streptococcus fecalis	6 per cent
(8)	Paracolon	4 per cent
(9)	Alcaligenes fecalis	4 per cent

There are seven drugs most commonly used to combat these infections, namely, arsphenamine, mandelamine, streptomycin, aureomycin, chloromycetin, gantrisin and terramycin.

As in vivo and in vitro study (fig. 1) of the effect of these seven drugs on the nine organisms most commonly isolated may be summarized in this manner:

(1) Escherichia coli, which is the organism most commonly found in the urinary tract, fortunately is controlled, in most instances, by any of the drugs.

(2) Pseudomonas aeruginosa is the most resistant organism in infections of the urinary tract, and as yet there is no nontoxic antibiotic that will always inhibit the organism. Certain strains, however, are controlled by streptomycin, aureomycin and terramycin. Clinically, mandelamine proves effective when the urine can be rendered acid. It is apparent that chloromycetin and gantrisin are not particularly effective in the pseudomonas infection.

(3) Aerobacter aerogenes is a fairly resistant organism, notably to streptomycin, chloromycetin and gantrisin; however, it is more susceptible to aureomycin and terramycin.

(4) Proteus is another difficult organism to treat. Practically all its strains split the urea in the urine into ammonium hydroxide and carbon dioxide, thus forming an alkaline urine. Chloromycetin and gantrisin are most effective in the treatment of proteus infections. Terramycin is totally ineffective as is aureomycin.

(5) Escherichia intermediate shows a high percentage of resistant strains to streptomycin and to gantrisin, but is highly susceptible to aureomycin or chloromycetin.

(6) Staphylococcus is best controlled by penicillin; however, aureomycin and chloromycetin are effective to a high degree.

(7) Streptococcus fecalis is controlled by aureomycin and chloromycetin; it is also highly susceptible to mandelamine.

(8) Paracolon is not often found in the urinary tract, but is controlled by aureomycin and terramycin.

(9) Alcaligenes fecalis is easily controlled by aureomycin and terramycin.

Nichols and Needham[2] found that 68 per cent of the strains of micrococcus pyogenes (staphylococcus) isolated from patients with infections are now penicillin resistant but aureomycin sensitive. Also, streptococcus fecalis was for the most part penicillin resistant but aureomycin sensitive.

Choice of Drug

The choice of drug depends on a number of factors: (1) tolerance, (2) toxicity, (3) tendency to develop resistance, (4) ease of administration, (5) effectiveness and (6) cost.

One must bear in mind that the chemotherapeutic agents, as fine as they may be, are but adjuncts to the relief of infection in the urinary tract, or for that matter wherever encountered. Infection will persist or recur if the obstruction is not located and relieved. Should infection reappear in the urinary tract after the initial administration of one of the drugs, a careful search should be instituted for the location and nature of the obstruction. This, in many instances, requires a cystoscopic examination.

Likewise, infection in the urinary tract may be initiated in some other part of the body and conveyed to the kidney or bladder by the hematogenous, lymphogenous or urogenous route; therefore, remote foci of infection should also be sought out.

IN VITRO SENSITIVITIES OF 641 ORGANISMS

ORGANISM	STREPTOMYCIN		AUREOMYCIN		CHLOROMYCETIN		GANTRISIN		TERRAMYCIN	
	SUSCEPTIBLE	RESISTANT	SUSCEPTIBLE	RESISTANT	SUSCEPTIBLE	RESISTANT	SUSCEPTIBLE	RESISTANT	SUSCEPTIBLE	RESISTANT
ESCHERICHIA COLI	111	20	119	7	119	2	77	41	82	1
ESCHERICHIA INTERMEDIATE	15	20	(37)	2	(27)	7	9	25	14	7
AEROBACTER AEROGENES	22	39	(62)	9	26	48	2	55	(32)	7
PARACOLON COLIFORME	10	6	(16)	3	9	6	9	5	(5)	1
PSEUDOMONAS AERUGINOSA	16	59	17	57	6	61	5	71	23	17
PROTEUS VULGARIS	37	11	5	56	53	11	(35)	14	2	27
ALCALIGENES FECALIS	3	20	(20)	1	10	13	6	17	(17)	1
STREPTOCOCCUS FECALIS	21	14	(43)		(30)	2	9	26	25	7
STAPHYLOCOCCUS	23	19	(39)	4	(29)	3	11	21	25	16
FUNGUS INFECTIONS										

SUSCEPTIBILITY LEVELS
STREPTOMYCIN 8 MCG/CC.
AUREOMYCIN 1 MCG/CC.
CHLOROMYCETIN 16 MCG/CC.
GANTRISIN 10 MG/CC.
TERRAMYCIN 23 MCG/CC.

Figure 1

DRUG OF CHOICE		
ORGANISM	FIRST CHOICE	SECOND CHOICE
ESCHERICHIA COLI	MANDELAMINE	TERRAMYCIN
ESCHERICHIA INTERMEDIATE	AUREOMYCIN	CHLOROMYCETIN
AEROBACTER AEROGENES	AUREOMYCIN	TERRAMYCIN
PARACOLON COLIFORME	AUREOMYCIN	TERRAMYCIN
PSEUDOMONAS AERUGINOSA	TERRAMYCIN	
PROTEUS VULGARIS	GANTRISIN	CHLOROMYCETIN
ALCALIGENES FECALIS	AUREOMYCIN	TERRAMYCIN
STREPTOCOCCUS FECALIS	AUREOMYCIN	MANDELAMINE
STAPHYLOCOCCUS	PENICILLIN	CHLOROMYCETIN

Figure 2

The sensitivity tests are exceedingly important determinations in the resistant cases. Although the serial tube test is the most accurate, it is also the most complicated. The disk method has become popular because it can be accomplished in the office if an incubator is available.

No one formula can be applied to every patient, but individualization of the patient and the drug (fig. 2) is necessary to take full advantage of the modern concepts of treatment. The old dictum of "treating the patient and not the disease" still holds true.

In closing I should like to quote a portion of the editorial[3] appearing in the Journal of the American Medical Association on "New Antibiotics:" "The task of the physician in the future will not be simplified by introduction of new drugs. On the contrary, he will be faced with new problems. He will have to maintain close cooperation with the bacteriologic laboratory to be informed about the species of the causative agent, its susceptibility to a long series of antibiotics and the blood levels." Taking up this task and utilizing the facts now known will bring their reward.

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Safeguarding the Part Time Florida Patient

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Perennially, Florida physicians encounter the problems incident to caring for the part time patients who invade the state year in and year out during the winter season. Improved professional relations, therefore, with the physicians who advise their patients to come to Florida for their health would seem to be an objective worthy of cultivation in the best interest of these patients.

The patient sent to Florida for his health is a living, thinking human being as are all of us. Living, thinking human beings change from day to day and even minute to minute. Just as a patient hospitalized for pneumonia can have appendicitis while in the hospital, so the patient sent to Florida can experience an illness different from the one which caused his physician, when he last saw him, to recommend change of climate as a therapeutic measure.

Some problems in professional relations encountered in the care of patients sent to Florida for their health we have not liked and should not like to have repeated. For example:

1. In some patients under our care who were sent to Florida for postoperative convalescence, acute coronary occlusion has developed. While holding the confirmatory evidence in our hands, we have been told over the long distance telephone

Read before the Florida Heart Association, Third Annual Meeting, Hollywood, April 22, 1951.

by their attending physicians that the condition they obviously had could not have developed in these patients.

2. We have called distant attending physicians for advice about their patients who had pneumonia and have been told to send them back by airplane immediately, regardless of their condition. In one such instance, the patient had a temperature of 105 F. at the time.

3. We have attended patients with poor operative results who had been advised that climate would cure them. We recall in particular a patient removed from the train to the hospital by ambulance, who stayed in the hospital two and a half months. At the end of that time his remains were shipped North.

4. There have come under our observation patients with advanced cardiac disease in whom subacute failure developed in the railroad station en route to Florida, through hurrying to catch their train in order to come here for a "rest."

5. Patients referred by distinguished colleagues have failed to come to us on arrival. We have seen them for the first time days to weeks after they had arrived, often in acute failure and sometimes with their condition complicated by acute alcoholism.

6. We have known divorce to result from one parent accompanying a child with rheumatic heart disease to Florida while the other parent remained at home.

Florida's Advantages

Since our colleagues away from Florida are probably more impressed than we are by climatotherapy, it might be well for us to consider what our climate has to offer. Clarifying these advantages both for us and for them, particularly as applied to patients with cardiovascular disease, would perhaps be helpful.

Florida offers in most seasons a subtropical climate which permits outdoor living and the use of much less clothing, probably 8 to 14 pounds less than in Northern climates during the winter. It provides a moist air so that the body need not work so hard to warm and moisten air, and thus the cardiac patient breathes easier and with less effort. Also, many patients with peripheral vascular disease are free of symptoms because of these factors. There is relative freedom from the common pollens in most sections of the state, and the climate is therefore beneficial to those cardiac patients who have the complications of allergic asthma.

During most years infections of the upper part of the respiratory tract occur with considerably less frequency than in Northern climates. For some reason, the incidence of streptococci infection of the throat and other streptococci infections is less than in Northern climates, even during the seasons when we have virus pneumonia and other viral infections. Florida also offers a more leisurely tempo of living than that which prevails in the more highly industrialized Northern areas.

These seem to us to be the chief advantages of our state from the health standpoint. They have been sufficient to induce many people to establish their home here and many more to spend two to eight months of the year in Florida.

It is the group of patients who make long visits yearly or occupy homes in the state for a part of the year who necessarily must have a physician here as well as one in their Northern homes. We wish particularly to stress the importance of good understanding and cordial relationship between these two doctors, and the importance of not allowing the patient to fall between their divided responsibilities nor to become confused by their different outlooks on disease.

Suggestions to Northern Colleagues

Our Northern colleagues could be most helpful to us and in turn to their patients in these particulars:

We would like them first to take more pains about the details of transportation so that the patients will arrive safely. A wheel chair trip through a terminal is much less humiliating to a cardiac patient than acute heart failure on the train or plane en route here.

We would like to have patients who are to come under our care referred to us directly by their physicians. We even find that we do better with patients of doctors who are classmates, or who know us or have met us at conventions and meetings than we do with patients from doctors whom we have not met.

We would like to see these patients shortly after their arrival here. In that way we have an opportunity to observe them before we are needed in an emergency and often we can advise them against:

1. Too sudden assumption of strenuous activities. Many patients feel so much better here that they believe they are stronger than they are. One patient who had to stop twice in one block because of angina in the North first consulted us

for a "cold" that developed while he was turning somersaults under the water while swimming. Needless to say, the "cold" was acute left ventricular failure.

2. Excessive drinking. In any area where large numbers of people are idle, for reasons of health or other reasons, excessive drinking occurs, also excessive card-playing and other social activities.

3. Excessive sun bathing. The rays of the sun are so strong that even people who have lived here all their lives will blister and run a fever on excessive exposure. In the sunburn cases we see, pedal edema and casts and albumen in the urine are often present. We try to explain to the patient that the body must do a considerable amount of work to keep the temperature normal when it is exposed to the sun, so that sun bathing represents exercise, not relaxation. The effects of excessive heat, in causing oxygen lack in the extremities in cases of peripheral vascular disease, are of course too well known even to mention.

We would like our Northern colleagues to send us, or send by the patients, their records, electrocardiographic tracings and lists of medications. We frequently have to hospitalize a patient for several days before we can be sure that the vague symptoms and abnormal electrocardiograms are not indicative of acute coronary occlusion. A previous tracing would save long distance telephone calls for us and time for the patient. On medications, we remember one instance when a patient told us she took "thyroid medicine," which we assumed was thyroid gland. A blood count revealed a leukopenia, and a long distance call disclosed that it was thiouracil she was taking. We even find it an advantage in many cases to label our patients' medicines on the bottles, giving both the name of the drug and the amount.

We would like, too, to receive our Northern patients free of infections of the upper part of the respiratory tract. In cases of rheumatic carditis, we find that if the patient has already had his first fall infection before arriving here, his course will be little different than it would have been in the North. We are strongly of the opinion that patients with this disease should remain here until May or June.

In most instances it seems to us that ordinary virus infections are contracted on the train or plane en route here. For several years we have used influenza A & B vaccine. The recommended 1 cc. dose, particularly in older people, often causes a fever and discomfort. We have used 0.6 cc. per dose for two doses, two days apart, without causing a reaction, and with, we believe, fair results. It should be given a month before the patient travels to Florida, and a month before the expected return North.

We would like, also, to have our colleagues in the North carefully select the patients they advise to come to Florida. We doubt that it is advisable to separate a husband and wife for the sake of a child with rheumatic heart disease. We think, too, that the economic status of the patient should be considered. Expenses here are for the most part comparable with those in Eastern seaboard areas, and probably considerably higher than those in Midwestern and Western areas. Unless the patient can afford the expense of living and traveling, and the possible expense of intercurrent illness, his worry over finances may rob him of the benefits of our favorable climate. We have seen this happen.

Our Responsibilities

These suggestions to our distant colleagues remind us of our own responsibility to our part time patients. In the first place, we should not make changes in their treatment, if they have done well on that treatment, unless changes in their condition demand such alteration. We have cardiac patients with diabetes from all sections of the country on many different regimens, and as long as the patient does well, we do not force him into our own regimen. We admit a prejudice against the use of mercury salts intravenously, which we find many patients taking and which we consider dangerous, and we often refuse to carry out this treatment.

We should make no radical change in a patient's treatment shortly before his departure for the North, unless it is emergency treatment, because we will have no chance to evaluate it. We even refuse to make extensive diagnostic tests shortly before a patient leaves unless they are really for emergencies. Instead, we advise him to wait and have them made nearer home.

We should not recommend that elective surgery be performed locally. We have seen many instances of disgruntled patients who have undergone surgery only to have complications or results follow which did not please them. We believe that these patients would have been better satisfied if their home town surgeons had handled them. We strongly recommend to our Northern colleagues

who send patients here that elective surgery be performed on their well compensated cardiac patients because we have seen too many emergency operations on urinary tracts, gallbladders, strangulated hernias and the like, in patients in their eighth or ninth decade. In retrospect, we wish that these patients had been subjected to surgery earlier. It seems that most cardiac patients who come to Florida far exceed the usual life expectancy. It would appear to be an advantage in most instances for them not to have the year of inconvenience that these correctible surgical situations caused, not to mention the danger of having emergency operations at advanced ages.

We, too, should return our patients to their home town physicians with clear, concise and complete records. A patient's garbled account of the findings, statements and medications given can cause serious misunderstandings between his two attending physicians.

We should also give much consideration to our patients' travel arrangements. We have found that there is a great difference in traveling south to get here and in traveling north to the patient's home. In coming here, the patient is arriving for convalescence in a new and often, to him, strange atmosphere. In traveling north, he is returning to his home and to the physician he knows best. Often he must be returned home in seriously ill condition.

Another consideration is that airplane flights headed south, even in bad weather, will continue because they are sure of safe weather conditions for landing. Flights headed north, however, will be grounded in bad weather, and the patient may have bus trips or taxi trips to railroad stations, and often long periods of waiting. Another disadvantage of airplane travel is that the patient cannot lie down, and there is no privacy if he becomes ill. Besides, the air travel companies do not want to transport seriously ill patients.

Train travel represents the best and safest means of transportation for ill patients because they can be at bed rest, they have privacy, and they are sure of arriving at their destination within a few hours of the announced time. Most patients can be put aboard the train by ambulance and a small chair. Lifting them by stretcher through the train window is a frightening experience for the patient and should be reserved for only the worst cases. Regardless of the mode of travel, the nurse, companion or relative who accompanies the patient should be well supplied with medicines, syringes and supplies to cover any emergency. Often we supply them with a list of physicians in the large towns along the route.

By far the worst method of travel is by automobile, at least for the cardiac patient. Even healthy persons often arrive here by car exhausted and with pedal edema caused by the long hours in a sitting position, the heat and high salt content of the food available along the road. We have even seen cases in which thrombophlebitis of the legs developed in otherwise healthy persons from riding in a cramped position in an automobile. Frequently we see patients who started out well compensated but in whom heart failure developed before the end of their trip. Often these patients have become ill in small towns without hospital facilities and have had to be treated and sometimes sent long distances by ambulance to hospitals. If automobile travel is contemplated at all for the cardiac patient, it should only be considered with the understanding that 200 miles a day will be the maximum distance traveled, and that reservations for rooms en route will be made in advance.

All of these matters are so small or so obvious as to seem inconsequential, but they deal with management of the patient and with proper care for him. They must be considered if the patient is to get maximum results from his stay in Florida.

Finally, we ourselves and our Northern fellow physicians should not by sweeping generalization of the characteristics of the medical profession in a particular location, or by word or deed or even facial expression, do anything that would cast doubt on the ability or judgment of each other unless there are good and valid reasons for so doing. In an argument, disagreement or assumption of a critical attitude between two attending physicians on the same case, it is always the patient who loses the most. We can help the patient best by inspiring in him confidence in our abilities and judgment, and that is what we as physicians should all strive to do.

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Use of Intra-Arterial Aminophylline for Peripheral Arteriosclerosis

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The introduction of intra-arterial therapy added a new method of helping the patient with peripheral arteriosclerosis. Up until that time the only active therapy was through blocking or removing the sympathetic ganglions or nerves to the part. The use of intra-arterial histamine by Mufson and his associates[1] was a new form of active therapy, but in my personal experience, the technic is complicated and the results short-lived. In this area, several physicians have been using intra-arterial procaine with good results in spastic cases, but transitory benefit in the arteriosclerotic case.

The xanthine drugs exert a local dilatory effect on blood vessels. The effect on the arteriosclerotic patient may be through two methods: (1) local dilatation, and (2) increased cardiac output. The most pronounced and prolonged local effect of this group is obtained with theophylline and ethylenediamide (aminophylline). Many workers have demonstrated dilatation of the coronary arteries with this drug.[2-4]

In November 1947 I started using aminophylline intra-arterially. At first I employed it only as a last resort in those case with impending gangrene. Later, I used it in cases with gangrene in which delay of amputation was desirable, and in cases with infection in conjunction with intra-arterial penicillin. Lastly, after being thoroughly convinced of the effectiveness and safety of the procedure, I used it in all cases that had not responded to simple means of treatment.

Technic

The method of administration is so simple that I have been using this technic as an office or a home procedure. The femoral pulse must be palpable. A routine type of surgical preparation of the groin and thigh is carried out. After the area has been shaved and thoroughly cleaned with alcohol and ether, and painted with one of the standard antiseptics, the artery is carefully palpated and held firmly between the index and middle finger of one hand. With the other hand, a 5 cc. syringe with 2 per cent procaine and a 22 or 23 gauge 2 inch needle is introduced 2 inches below the inguinal ligament and is directed cephalad; the subcutaneous tissue is infiltrated with the procaine, and a good periarterial infiltration is obtained. With approximately 2 cc. left in the syringe, the artery is penetrated with the last ½ inch of the needle at an angle of about 30 degrees. The last 2 cc. of novocain is injected into the artery slowly. The syringe is disconnected from the needle, and a 20 cc. syringe with 3¾ grains of aminophylline is immediately attached and injected, the injection being given in about two minutes. The needle is immediately withdrawn, and moderate pressure is maintained for fifteen minutes. The patient lies down for one hour following the injection. I have found it advantageous to give 1½ grains of a fast acting barbiturate a half hour before the injection is made.

Results

To date, over three hundred injections have been made without a single mishap. No thrombosis has followed the procedure, and no infection has occurred. It is possible by this means to obtain good vasodilatation even after a good sympathectomy has been performed. This technic will relieve claudication that sympathetic blocks or sympathectomy have not helped at all. The

Read in part before the staff of Mt. Sinai Hospital, Miami Beach, June 1949.

dilatation that follows the intra-arterial injection takes place slowly. Occasionally, no heat is felt below the knee for twelve hours; but the dilatation will last several days. In contrast to sympathetic block, it is not unusual to find an increased oscillometric reading the next day.

For aged arteriosclerotic patients, no single method of treatment has yielded as gratifying results as intra-arterial aminophylline. In the average case only two or three blocks need be given. Some of these patients have had no recurrence of claudication in one year of follow-up. As many as seven intra-arterial punctures have been made in a two week period in one patient with no untoward results; and fourteen injections have been made in another over a two month period with no apparent damage to the artery. In popliteal thrombosis, I believe that this is definitely the treatment of choice. In 2 such cases I have observed great improvement, but in 8 others there was no notable response following sympathectomy. In my opinion this difference is due to the fact that with intra-arterial injection dilatation of the muscular arteries occurs if any of these pathways are open, while it is definitely open to question if sympathectomy affects muscular vessels to any degree.

Certainly it is known that muscular temperature and oscillometric readings do not increase following good sympathetic block in an arteriosclerotic patient.

In the vasospastic patient, I believe that sympathetic surgery is a superior means of treatment. The results are more dramatic and effective as a rule. In mild thromboangiitis obliterans, the dilatation will usually not be noticed until the next day with intra-arterial aminophylline. In an occasional case, however, in which the claudication is not relieved by sympathetic block, considerable benefit will be received from intra-arterial aminophylline. It must be mentioned that patients subjected to sympathectomies or sympathetic blocks respond better to intra-arterial aminophylline, and this response is better than either procedure used alone. At the present time, in cases in which the risk is good, I believe sympathectomy should be performed first and then followed by intra-arterial aminophylline therapy.

Conclusion

A new approach to the active treatment of peripheral arteriosclerosis is presented. The use of intra-arterial aminophylline will give active vasodilatation and increase the peripheral circulation safely. It should, of course, be used with other medical measures, as no isolated method of treatment of this systemic disease can be successful in itself.

In the last group of injections the procaine and aminophylline are mixed before injection, and the injection is given over a four minute period. This procedure gives virtually no symptoms during injection.

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The Scientific Department of The Journal
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The Editor Invites Your Contributions
On Data of Notable Interest

A Consolidated Screening Survey in Seminole County

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Throughout the past few years, much has been said and written about so-called multiple testing. This in general means performing screening tests on a population by using more than one procedure or searching for more than one pathologic condition. As a project, this is not historically recent. A combined survey for syphilis and tuberculosis was carried out in Savannah, Ga., in 1941. There has, of course, been greatly renewed interest in the subject within the last two or three years. Surveys have varied all the way from a combination of two tests to elaborate tests being carried out in Massachusetts employing some 17 procedures. The thinking of the public health profession in Florida has been toward the more conservative side of the picture. We have not been interested in introducing many new types of procedures as yet not fully investigated. We have, however, been interested in combining some of our screening endeavors which are already being carried out, which plan we believe would lead to increased efficiency of operation.

The idea of multiple testing is not new even in Florida, since many small projects have been carried out using two or more procedures. The purpose of this paper is to report an experimental project which was designed to determine if a combination of all screening procedures now being carried out could be possible with the use of only a minimum of new resources and personnel.

For several reasons the area of operation was designated as Seminole County. The schedules of the various screening teams could be consolidated so that testing could be carried out in this county. It is a county of fairly average size in population and, of course, has a well organized health department. These and other considerations entered into the decision.

Read before the Florida Health Officers' Society, Sixth Annual Meeting, Hollywood, April 22, 1951.

A series of preliminary conferences was held with the health officer of Seminole County and with the various bureau and division chiefs of the State Board of Health engaged in screening procedures. All these officials thought that such a

Table 1.–Total Positive Results All Tests

Age Group	Total Tested	Per Cent Dist.	Positive	Per Cent
WHITE MALE				
0-24	392	6.8	15	3.8
25-44	551	9.5	14	2.5
45-64	443	7.6	30	6.8
65-	220	3.8	39	17.7
Not Stated	4	0.1	0	—
Total	1,610	27.8	98	
Total no blood specimen — 127 or 7.9 per cent				
WHITE FEMALE				
0-24	530	9.1	46	8.7
25-44	875	15.1	29	14.7
45-64	595	10.3	58	9.8
65-	193	3.3	28	14.5
Not Stated	4	0.1	1	25.0
Total	2,197	37.9	162	
Total no blood specimen — 20 or 2.2 per cent				
NEGRO MALE				
0-24	273	4.7	31	11.4
25-44	390	6.7	84	21.5
45-64	187	3.2	58	31.0
65-	65	1.1	25	38.5
Not Stated	6	0.1	0	—
Total	921	15.8	198	
Total no blood specimen — 20 or 2.2 per cent				
NEGRO FEMALE				
0-24	316	5.5	76	24.1
25-44	331	7.4	158	36.7
45-64	190	3.3	58	30.5
65-	38	0.7	12	31.6
Not Stated	4	0.1	1	25.0
Total	879	17.0	305	
Total no blood specimen — 73 or 7.5 per cent				

combined project was practical and should be attempted. A decision was then made as to the tests that were to be offered and the general procedures to be carried out. In spite of the fact that all these procedures had been approved by the local medical society individually, this organization was requested to approve the idea of consolidation of the testing. This approval was given, and cooperation was pledged. Following this agreement, many detailed conferences on the technics of operation were carried out both at the state and county level. The survey began on February 23 and ended on March 3, 1951.

The procedure carried out consisted of the usual 70 mm. roentgenogram of the chest, followed by venipuncture to obtain a specimen of blood. This blood specimen was divided into two parts, one of which was added to an anticoagulant and the other allowed to clot. The clotted specimen was then examined for evidence of syphilis by screening with the VDRL test followed by quantitative Kahn examinations in specimens with positive results. The oxalated blood was examined for the hemoglobin level by the acid hematin method and for the level of sugar by the Wilkerson-Heftmann rapid blood sugar screening method, followed by the Nelson blood sugar procedure in positive specimens. An arbitrary level of 11.5 Gm. of hemoglobin was chosen as the screening level, and the usual criteria employed in individual surveys were used in the other screening procedures. The policies with regard to reporting of results and referrals to physicians used in all surveys conducted in cooperation with the State Board of Health were carried out. Local referrals were carried out by the county health department, and follow-up work is still going on at the present time.

Some comment as to community organization might be of interest. The combined test was given the name of "health test" for public consumption.

Table 2.-Positive Roentgenograms—Suspected Tuberculosis

Age Group	White M	White F	Negro M	Negro F	Total
0-24	0	2	0	0	2
25-44	1	1	0	1	3
45-64	5	3	0	1	9
65-	5	6	1	2	14
Total	11	12	1	4	28

Table 3.-Positive Roentgenograms—Suspected Cardiovascular Disease

Age Group	White M	White F	Negro M	Negro F	Total
0-24	0	0	0	0	0
25-44	0	0	0	0	0
45-64	1	5	5	3	14
65-	4	2	1	0	7
Total	5	7	6	3	21

Table 4.-Positive Roentgenograms—Other Chest Pathology

Age Group	White M	White F	Negro M	Negro F	Total
0-24	0	0	0	1	1
25-44	0	6	1	1	8
45-64	2	3	3	2	10
65-	5	0	4	1	10
Total	7	9	8	5	29

Table 5.-Positive Syphilis Serology by Age, Sex and Color

Age Group	White M	White F	Negro M	Negro F	Total
0-24	0	0	21	20	41
25-44	5	10	65	66	146
45-64	6	5	41	23	75
65-	8	4	12	3	27
Not Stated	0	0	0	1	1
Total	19	19	139	113	290

Of this group 107 were previously reported

Table 6.-Abnormal Hemoglobin Levels

Range 11.5 — 9.5 Gm.

Age Group	White M	White F	Negro M	Negro F	Total
0-24	9	39	8	47	103
25-44	5	79	11	69	164
45-64	7	33	3	24	67
65-	9	12	4	7	32
Not Stated	0	1	0	0	1
Total	30	164	26	147	367

Range 9.4 — 7.5 Gm.

Age Group	White M	White F	Negro M	Negro F	Total
0-24	5	4	0	8	17
25-44	0	12	2	15	29
45-64	0	4	1	1	6
65-	1	1	1	0	3
Not Stated	0	0	0	0	0
Total	6	21	4	24	55

Range 7.4 Gm. and below

Age Group	White M	White F	Negro M	Negro F	Total
0-24	0	0	0	0	0
25-44	0	3	0	3	6
45-64	0	1	0	0	1
65-	1	0	0	0	1
Not Stated	0	0	0	0	0
Total	1	4	0	3	8

Lowest hemoglobin 5.8 Gm. (WM 85)

It was thought that this term would convey the meaning better than several others which were considered. The usual radio and press publicity was carried out, and, in addition, 50 posters were prepared by the Day-Glo process. The Seminole County Tuberculosis Association was most helpful and furnished the majority of the volunteer clerical help necessary for the survey.

The public response was particularly gratifying. In 1949 the Bureau of Tuberculosis screening team obtained 5,192 screening roentgenograms in Seminole County. During the combined screening survey, a total of 5,801 roentgenograms were obtained, an increase of 12 per cent over the former year. This indicates that combination with a procedure which "hurts" did not materially damage the success of the roentgen survey. All the local agencies, including the medical profession, have informally expressed their satisfaction with the project and believe that it was well worth while.

Table 7.–Abnormal Blood Sugar—Not Previously Known

Age Group	Range 160-199 mg. W M	W F	N M	N F	Range 200-299 mg. W M	W F	N M	N F	Range 300+ mg. W M	W F	N M	N F	Total
0-24	1	1	1	0	0	0	0	0	0	0	0	0	3
25-44	2	8	2	1	1	4	1	0	0	0	1	0	20
45-64	4	0	1	0	2	0	2	1	1	0	1	1	13
65-	2	1	0	0	2	0	0	0	1	0	0	0	6
Total	9	10	4	1	5	4	3	1	2	0	2	1	42

Highest blood sugar 470 (CM 45)

Table 8.-Abnormal Blood Sugar—Previously Known

Age Group	Range 160-199 mg. W M	W F	N M	N F	Range 200-299 mg. W M	W F	N M	N F	Range 300+ mg. W M	W F	N M	N F	Total
0-24	0	0	0	0	0	0	0	0	0	0	0	0	0
25-44	0	2	0	0	0	0	0	0	0	1	1	2	6
45-64	0	0	0	0	0	0	1	0	0	4	0	1	6
65-	0	0	0	0	0	1	0	0	0	0	0	0	1
Total	0	2	0	0	0	1	1	0	0	5	1	3	13

Table 9.–Number of Diagnoses

Suspected tuberculosis	28
Suspected cardiovascular disease	21
Other chest pathology	29
Suspected diabetes mellitus	46
Previously known diabetes mellitus (with high blood sugar)	15
Previously known diabetes mellitus (with normal blood sugar)	29
Abnormal hemoglobin	430
Suspected cases of syphilis	183
Previously known cases of syphilis	107

Table 10.–Summary of Positive Results

Roentgenogram only	61
Roentgenogram (no blood specimen)	4
Roentgenogram, serologic reaction	8
Roentgenogram, serologic reaction, blood sugar	0
Roentgenogram, serologic reaction, blood sugar, hemoglobin	0
Roentgenogram, blood sugar, hemoglobin	0
Roentgenogram, blood sugar	0
Roentgenogram, hemoglobin	4
Roentgenogram, hemoglobin, serologic reaction	1
Serologic reaction only	233
Serologic reaction, hemoglobin	43
Serologic reaction, blood sugar, hemoglobin	1
Blood sugar only	61
Serologic reaction, blood sugar	4
Blood sugar, hemoglobin	5
Hemoglobin only	376
Persons with positive tests	735
Positive tests	801

Comment

It would appear that such an undertaking is practical and would, as it has in the case of Seminole County, contribute to better health for the people of Florida. Certainly, much greater evidence of ill health can be brought to light with employment of a few additional personnel. It is the general opinion of those associated with the survey that a properly balanced team would consist of one x-ray technician, two bloodletting technicians, and one or two history takers. Based on this number, only a few additional personnel need be obtained in order to carry out a survey at the same level employed in Seminole County. The increased volume in several of the procedures will necessarily mean some changes and development in the handling of specimens at the laboratory level. The development of a combined survey screening history form and concomitant report forms may also be indicated. The lessons learned in Seminole County will be of great value in bringing about these developments.

It is hoped that other county health officers and county medical societies will become interested in carrying out such a project in their areas. The State Board of Health stands ready to give the technical assistance necessary in so doing.

1217 Pearl Street.

The Greeks Had a Word For It

GEORGE A. DAME, M.D.
JACKSONVILLE

This is an excursion into philology. An excursion is defined as a jaunt or short journey for a special purpose. Philology is, of course, a love or study of words.

Let us, therefore, take a jaunt into the study of words for the purpose of creating a new word. This new word is to be a symbol of an idea which heretofore has required a series of words to identify it fully.

The Greek word "hygies" means sound or healthy, and its derivative "hygieia" means health or soundness. As was their penchant, the Greeks soon honored the idea as "Hygieia," the Goddess of Health. We have anglicized the word into "Hygeia."

In classical mythology, Hygieia, the Goddess of Health, daughter of Aesculapius, was usually represented as a blooming maid with a bowl in one hand and a serpent in the other.

Let us now consider derivatives:

Hygeian, a. Relating to Hygeia, the Goddess of Health, and to health and its preservation.

Hygieist or Hygeist, n. A hygienist.

Hygiene, n. Health; the department of natural science which treats of the preservation of health.

Hygienic, a. Pertaining to health.

Hygienically, adv. In a hygienic manner; in a manner fitted to preserve health.

Hygienics or Hygienism, n. The science of health; hygiene; sanitary science.

Hygienist, n. One versed in hygiene or the science of health.

Hygiology, n. The science of, or a treatise on, the preservation of health.

The word hygeian could be converted from an adjective to a noun and would almost serve our purpose, but not quite. The word hygienist is too broad in its meaning. Paraphrasing, it covers a multitude of sinners, as for example, nurses, educators, dentists and veterinarians. We wish to coin a word specifically referring to medical doctors who are trained and skilled in the art and science of hygiene, or literally, preventive medicine and public health.

For the sake of euphony and for the sake of being specific, let us now coin the word *Hygenian*. It is a noun, specific, euphonious, dignified, and easily rolled off the tongue.

As an example of the derivation of words and of the coining of new words based on old words, let us take the fine word "surgeon." This word is derived from the archaic word "chirurgeon;" from the French, "chirurgien;" from the word "chirurgie," meaning surgery; from the Greek, "cheirourgia;" from "cheirourgos," working or operating with the hand; from "cheir," hand, plus "ergon," work.

Give some thought to the proposed word symbol of the idea it is coined to express. We have the excellent words physician, surgeon, sanitarian, and nurse. Let us also have the fine word *Hygenian*.

Reference

Webster's New International Dictionary, ed. 2.

Read before the Florida Health Officers' Society, Sixth Annual Meeting, Hollywood, April 22, 1951.

1217 Pearl Street.

A. M. A. Clinical Session
December 4-7, 1951
Los Angeles

A. M. A. Public Relations Conference
December 2-3, 1951
Los Angeles

ABSTRACTS OF MEDICAL ARTICLES

HEMANGIOMA OF THE KIDNEY. By Arthur J. Butt and Joseph Q. Perry. J. Urol. 65:15-19 (Jan.) 1951.

The authors present a case of hemangioma of the kidney which was diagnosed preoperatively. They note that Virchow described the first case from an autopsy specimen in 1867 and that Fenwick in 1903 was probably the first to recognize the lesion clinically; their case brings the total reported in the literature to 55. They express the opinion that more exhaustive examinations of the kidneys would reveal that more cases of so-called essential hematuria may be due to hemangioma.

In the differential diagnosis of benign and malignant tumors of the urinary tract, they believe the study of urinary sediment for malignant cells may prove of great value. They advise that conservative surgery, such as resection of the part of the kidney containing the tumor, may be carried out in some cases in which a diagnosis of benign renal vascular tumor has been made.

THE USE OF DIBENAMINE IN THE SEVERE ASTHMATIC STATE AND RELATED CHRONIC PULMONARY CONDITIONS. By S. D. Klotz, M.D., and Clarence Bernstein, M.D., F.A.C.A., F.A.A.A. Ann. Allergy 8:767-771 (Nov.-Dec.) 1950.

The authors report using dibenamine as a therapeutic adjunct in cases of severe bronchial asthma and chronic pulmonary diseases with anoxia with some excellent results. They explain that this new adrenergic blocking agent is believed to be of value in these states by virtue of its sympathoadrenalytic effect which reverses the vasopressor responses to epinephrine but does not alter its inhibitory effect on the bronchial musculature. In this manner the increased pulmonary arterial tension and congestion that develop are decreased, and consequently both the pulmonic and systemic circulations are improved. They note that dibenamine appears also to increase the body tolerance for sympathomimetic substances as well as the sensitivity to their inhibitory effects, a property that may be of particular help in so-called "adrenaline-fast" states.

LEIOMYOSARCOMA OF THE JEJUNUM. By Richard M. Fleming, M.D., F.A.C.S., F.I.C.S., and Julius R. Pearson, M.D., F.A.C.P. J. Internat. Coll. Surgeons 14:547-553 (Nov.) 1950.

Though uncommon, malignant neoplasms of the small bowel should be included as a possibility in differential diagnosis of acute abdominal emergencies, especially those suddenly ushered in by the syndrome of shock and intestinal hemorrhage or obstruction. These authors substantiate this view by presenting a case of leiomyosarcoma of the jejunum, a rare entity developing in the muscularis, growing into the subserosa or the intestinal lumen, and metastasizing through the blood stream to local or distant tissues or structures.

They stress early diagnosis, the helpfulness of diagnostic roentgen procedures when there is time, radical resection of the local lesion as the treatment of choice, and when this is no longer possible, irradiation as a palliative measure.

THE PHYSIOLOGICAL PRINCIPLES IN RHINOPLASTY. By Samuel Fomon, M.D., William Y. Sayad, M.D., Alfred Schattner, M.D., and Harry Neivert, M.D. Arch. Otolaryng. 53:256-276 (March) 1951.

Since rhinoplasty has become a rather commonplace surgical procedure in the work of the younger otolaryngologists, the authors have attempted to correlate nasal physiology as a basis for certain necessary rhinoplastic procedures from the standpoint of function. The phylogenetic and ontogenetic development of the nose to meet a physiologic need, therefore, is discussed. The physiologic, clinical and surgical importance of the nares is stressed. The relationship between deformities of the external nasal pyramid and function is discussed. The role played by the nose in regulating intrathoracic, sinus and middle ear pressures is reviewed. The manner in which the nose prevents hyperventilation or hypoventilation is demonstrated. The effect of nasal stenosis on lung ventilation and air mixing is shown, and the aid given by the nose to the cardiovascular system is elaborated. The article is well illustrated.

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VOLUME XXXVIII
NUMBER 4

The Journal of the Florida Medical Association

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October Anniversaries

OCTOBER 1. October 1 may be called the Medical New Year. Old French and Medical guilds frequently held festivities which began on September 27, name day of the patron saints of medicine, Cosmas and Damian, and ended with a banquet on October 1. The College of St. Come (Cosmas) was founded in Paris in 1210.

OCTOBER 5. The first issue of the London Lancet is dated Oct. 5, 1823. Early volumes contained not only medical and surgical lectures delivered in the London hospitals of that day, but comments and quotations from outstanding men of literature such as Byron, Coleridge, Lamb and Southey.

OCTOBER 7. The Harvard Medical School was opened on Oct. 7, 1783. Using clinical and anatomic material furnished by the Continental Army Hospital established in Boston in 1780, Dr. John Warren began a series of lectures for Harvard students that year. Later, he drew up a plan for organization of the medical school which was accepted by the Harvard Corporation in 1782. The following year Drs. John Warren, Aaron Dexter and Benjamin Waterhouse began the long, honorable course of medical instruction at that institution.

OCTOBER 16. The anniversary of the first use of ether in a major operation, performed by Dr. J. C. Warren on Oct. 16, 1846 with W. T. G. Morton administering the ether, is commemorated at the Massachusetts General Hospital each year. The term anesthesia was suggested by Dr. Oliver Wendell Holmes. Dr. Crawford W. Long of Danielsville, Ga., etherized a patient and excised a small cystic tumor from his neck four years earlier, on March 30, 1842. A much earlier anesthetic was the soporific sponge known to the East Indians and to Dioscorides in the first century. Such a sponge was steeped in a mixture of opium, hyoscyamus, mulberry juice, lettuce, hemlock, mandragora and ivy, dried; it was to be moistened when inhaled by the patient. Shakespeare wrote:

> Not poppy, nor mandragora,
> Nor all the drowsy syrups of the world
> Shall ever medicine thee to such sweet sleep

OCTOBER 18. October 18 is the day dedicated to St. Luke, the physician — patron saint of all medicine. The latest account of his life, just off the press, is "The Road to Bithynia" by Dr. Frank G. Slaughter.

OCTOBER 19. Sir Thomas Browne of Norwich, England was born on Oct. 19, 1605 and died exactly seventy-seven years later, on Oct. 19, 1682. He was educated at Winchester, Oxford and for three years on the Continent, receiving his medical

degree at Leyden. Religio Medici, his great work of this early era which has influenced the lives of many physicians, apparently was written when he was only 29 years of age. James Russell Lowell classified Browne as having "our most imaginative mind since Shakespeare," while William Osler in ranking physicians of literary ability placed him second only to Rabelais.

October 21. John Whitridge Williams of Baltimore, born on Jan. 26, 1866, was professor of obstetrics at Johns Hopkins University School of Medicine from 1893 until the time of his sudden death on Oct. 21, 1931. Leader in a campaign for better prenatal care and lowering of maternal mortality, Dr. Williams taught many of America's outstanding obstetricians and was largely responsible for the development of obstetrics as one of the outstanding specialties.

Affectionately, but slyly, known as "The Bull," Dr. Williams was truly an institution unto himself. Taken rather suddenly ill in the fall of 1931, he died of massive hemorrhage from an ulcer on the posterior wall of the duodenum, which could not be demonstrated by x-ray. Following his death one of his young associates spent an entire lecture period telling anecdotes and giving reminiscences of "The Professor's" extraordinary personality. Students in that class, of which the writer was one, recall those incidents of two decades ago as if they had happened yesterday.

Dr. Williams' outstanding textbook of obstetrics, which first appeared in 1903, has gone through many editions. After the death of Dr. Williams, Dr. H. J. Stander of New York revised the text. The latest edition, the tenth, revised by Dr. N. J. Eastman of Baltimore, has recently appeared.

October 26? Hippocrates, son of the mythical Greek god of healing, Apollo, was born in the city of Cos in 460 B. C. His birthday was celebrated on the island of Cos on the twenty-sixth day of Agrianus, identifiable only as an autumn month. A contemporary of Socrates, Pericles and Aristophanes, and worthy of inclusion among the Athenians who were outstanding in philosophy, poetry and art, Hippocrates collected the knowledge and medical writings of that period, overthrew supernatural explanations of disease, and gave to Greek medicine its scientific spirit and lofty ideals. With case histories and physical examinations he founded bedside medicine. His humoral pathology has long been discarded, but his aphorisms and shrewd observations still hold. Some of his better known aphorisms are:

> If water is used for irrigation, it must be either very pure or else boiled, and the hands and nails of the operator are to be cleaned.
>
> Disease should be combated at its origin.
>
> If a man neglects nature's laws, he suffers.
>
> Life is short, art long, occasion brief, experience fallacious, judgment difficult; but treatment after thought is proper and profitable.

All physicians are acquainted with the Hippocratic Oath, and most strive to abide by its high ideals.



John Whitridge Williams
1866-1931

Courtesy, Journal of Obstetrics and Gynecology, November 1931, St. Louis, C. V. Mosby Co.

Character Delineated in Facial Expression

Down through the centuries the face has been considered an expression of character. Common to all animals except the very lowest, it was at first a primitive affair. Simply a trap for catching food, it proved very efficient, especially after the lower jaw, the only movable part, was added. In man and in all animals the face remains today merely a food-trapping mask; no other animal takes the liberties with his face, however, that man does, especially the female of the species, in whom it purportedly serves also as "a man-trapping mask." Too, it is by no means always a success esthetically in man, for who will deny that at times it is only a caricature of itself?

The muscles of expression could well be called the muscles of emotion. The smile or frown at breakfast may make or break the day and, habitually, set the tenor of one's life. There are sixteen of these muscles to which the human face owes its great power of expression. Most remarkable is the corrugator supercilii, the small horizontal muscle just above the eyebrow which knits the eyebrows and gives the idea of mind behind the face. The next most expressive is the muscle depressing the angle of the mouth, expressing the emotions of contempt, disgust and hatred.

The frontal muscle is the eyebrow-raiser, giving the expression of attention, or, if contracted enough, of astonishment. Also in the region of the eyebrow are the muscle of reflection, the superior orbital orbicular muscle, and the muscle of pain, the superciliary muscle. The muscle of laughter is the great zygomatic muscle, extending from its fixed attachment on the cheek into the deep surface of the skin of the commissure of the lips. The triangular muscle of the lips produces the expression of sadness, or of contempt, while the square muscle of the lower lip serves as the muscle of disgust.

So it is that these and the other muscles of the face in expressing emotion act upon the eyelids and lips, but chiefly on the corners of the eyes and of the mouth. They also act upon the nasolabial line, the furrow which runs from the side of the nose to the upper lip. In animals other than man, these parts have the least expression, for they have no eyebrows and no power of elevating or depressing the angle of the mouth.

One need hardly recall the stolid face of the Indian or the poker face of the gambler to be reminded that an habitual facial expression can be an indicator of a person's character. Unquestionably, there is justification for the century-old belief that a man's face portrays his character. And it shows there so plainly because the muscles of expression make the face wonderfully responsive to the emotions — good and bad.

To Dr. Harris D. Mosher of Marblehead, Mass., we are indebted for the delightful article on facial expression and body type as indicators of character, in the January 1951 Laryngoscope, from which we have gleaned these remarks. We would leave with you Dr. Mosher's closing thought: ". . . in the face, the muscles of joy and sorrow lie side by side. In life, joy and sorrow are side by side. Nature knew what was coming to us, because she provided only two muscles for joy — but four for sorrow. If you are an optimist, put this in your pipe and smoke it." Nevertheless, we would add, is it not true that the refining fire of sorrow adds strength to character?

Itemized Statements for Patients

In the interest of better public relations, the Illinois State Medical Society is urging physicians to itemize their statements to patients. Pertinently enough, it asks if you would pay your bill at the garage if it came to you this way, "Repair on 1948 car — $64.32." Would you not like to know that $8 went for checking the front end alignment; $1.25 for adjusting brakes; $1.25 for switching tires; $22.75 for parts, and the remainder for labor? This society thinks you would and also believes Mrs. Jones, likewise, would prefer to have the charges for Junior's latest illness broken down into the various items.

We quote from the Illinois suggestion:

"Perhaps Mrs. Jones didn't understand the charges for Junior's case of infectious mononucleosis; maybe she doesn't know what laboratory work is. Did you explain to her exactly what was wrong with Junior? Did you tell her why laboratory work had to be done? Does your bill carry the statement that you made a night call on Wednesday, June 20? If it does, maybe she'll remember how glad she was to see you.

"Or did you send Mrs. Jones a statement for 'Services rendered'?

"Think it over. Put yourself in Mrs. Jones' shoes and see if they pinch — just a little."

It occurs to us that if Mrs. Jones isn't too particular about the details now that Junior is well again, no doubt Mr. Jones would like the information for the record when he writes the check.

Survey of Physicians' Incomes

The first report of the results of a survey of the 1949 incomes of physicians in the United States was published by the United States Department of Commerce in its July Survey of Current Business.[1] This much discussed survey was a joint undertaking of its office of Business Economics and the American Medical Association's Bureau of Medical Economic Research. In this first article, the tabulations and interpretations are the responsibility of the Department of Commerce. Further analysis and study will be reported later by the Bureau of Medical Economic Research.[2]

In this broadest mail questionnaire survey of professional incomes ever made in the United States, with more than 55,000 physicians participating, there was one particularly significant general conclusion. In the twenty year period since 1929, the average net income of all civilian physicians more than doubled, but this relative increase was practically identical with that for all earners in the general population over the same period. Thus this study indicates that the average physician has been moving up the inflationary ladder only about as rapidly as the average American.

The increases in the earnings of physicians are credited to three factors: a moderate increase in fee schedules, better collections and greater "output per physician."

The finding that physicians' incomes rose about as fast percentagewise as the average income of the American people demonstrates clearly once more that there was no nation-wide shortage of physicians in 1949. Had there been, their mean and median net incomes for that year would have been far higher.

An average net income of $11,058, before taxes, represented the earnings of physicians in civilian practice, both salaried and independent, exclusive of interns, residents and teachers. Neurologic surgeons, pathologists and gynecologists, in order, had the highest earnings with an average net income of $28,628, $22,284 and $19,283, respectively. Physicians in private practice averaged $11,858 and salaried physicians, $8,272.

Among independent physicians, the average net income of $15,014 for full specialists was 70 per cent more than the average income of $8,835 reported by general practitioners. Part specialists reported $11,758.

About 13 per cent of the independent physicians made less than $3,000 net income for the year under consideration, whereas only about 9 per cent of the salaried physicians made so little. About 8 per cent of the independents, however, reported more than $25,000, but only 1 per cent of the salaried made as much.

For physicians who were members of partnerships, the average net income was $17,722. For those who were not members of partnerships, the figure was $10,895.

Nonsalaried physicians of the Far West received the highest mean and median net incomes, $14,235 and $12,243. Those in New England ranked lowest in both mean and median incomes, $9,602 and $7,818. In the Southeast, comprising eleven Southern states, these averages were $12,157 and $9,855, second from the lowest and fifth from the highest.

The study furnishes ample evidence that the highest average incomes are not being earned by physicians in the large metropolitan cities. It tends to emphasize the economic advantages of practicing medicine in the small and medium-sized cities, a matter of special interest not only to interns and residents confronted with the problem of choosing a location but also to the many physicians and lay leaders endeavoring to improve medical care in the smaller cities and towns of the rural parts of the country.

The government report covered some 30,000 of the 55,000 replies to the questionnaires sent to 125,000 physicians. "It is our opinion," said Dr. Frank G. Dickinson, the director of the Bureau of Medical Economic research of the American Medical Association, "that the national averages for the broad groups of physicians are generally reliable. We have some doubts about the averages for specialties, for specific cities and for states since the number of replies in each group provide, in some cases, a rather thin sample. Our subsequent analysis of the questionnaires may increase our confidence in these breakdowns."

1. Weinfeld, William: Income of Physicians, 1929-49, United States Department of Commerce, Survey of Current Business (July) 1951. A reprint of this article is available without charge from the Bureau of Medical Economic Research, American Medical Association, 535 N. Dearborn St., Chicago 10.
2. Income of Physicians, editorial, J. A. M. A. 146:1237 (July 28) 1951; also, Dickinson, F. G., and Bradley, C. E.: Survey of Physicians' Incomes, ibid., 146:1249-1255 (July 28) 1951.

Annual Fall Meeting Florida Academy of General Practice

SUNDAY, OCT. 14, 1951

SILVER SPRINGS

11:00 a.m. Meeting of Board of Directors
12:30 p.m. Luncheon
"The American Academy of General Practice, Its Past and Future Aims"
Dr. J. P. Sanders, National President of A.A.G.P., Shreveport, La.

SCIENTIFIC SECTION

Dr. E. E. Lietner, President, Florida Academy of General Practice, presiding
2:00 p.m. "The General Practitioner in American Medicine"
Dr. David R. Murphey, Jr., President, Florida Medical Association.
2:15 p.m. "Infant Feeding"
Dr. Walter W. Sackett, Jr., Miami
2:30 p.m. "Diseases of the Colon, Some Practical Points in Diagnosis"
Dr. John Cheleden, Ocala
2:45 p.m. Recess
3:00 p.m. "Medical Ethics of Today"
Dr. R. R. Killinger, Jacksonville
3:15 p.m. "The Therapy of Heart Failure"
Dr. George F. Schmitt, Miami

Three Years of Nationalized Medicine

When Britain's national health service celebrated its third birthday in July, we wonder how much pride the government took in the fact that half a million patients were on hospital waiting lists. Too, there were more than 10,000 patients with tuberculosis seeking admission to sanatoriums.

During the three years since the service started in 1948, druggists have dispensed an average of five prescriptions a year for every man, woman and child in the country. During the current year, Britain will expend about 1.3 billion dollars for nationalized medicine. Naturally, lack of resources and money becomes a bigger and bigger problem for the socialistic Labor government.

Not only in the light of Britain's experience but also in the light of plain common sense, it seems incredible that any loyal American citizen, much less government officials in high places, would advocate a government-controlled compulsory health program for this country.

Southern Medical Association Meets in Dallas, November 5-8

The Southern Medical Association will hold its annual meeting in Dallas, Tex., in November, one week earlier than usual. The activities of the convention will begin with the Opening Assembly on Monday, November 5, at 10:30 a.m. A feature of this session will be an address by Dr. John W. Cline of San Francisco, President of the American Medical Association, entitled "The Problems Confronting Medicine in the Immediate Future." The response to the address of welcome will be made by Dr. Elmer L. Henderson, a Past President of the Southern Medical Association, immediate Past President of the American Medical Association and President of the World Medical Association.

Beginning on Monday afternoon and continuing through Thursday afternoon, the association's twenty-one sections will hold forty-seven sessions. So diversified are the various programs that every physician will find his particular interests included.

President Curtice Rosser of Dallas will address the association at the dinner meeting on Wednesday evening, preceding the grand ball. The Adolphus and the Baker, the two large downtown hotels, will be the scene of most of the activities. The scientific and technical exhibits will be displayed in these two hotels, which are across the street from each other.

The completeness of the program, the excellence of the exhibits and the true Texas hospitality awaiting all who attend should make this meeting an outstanding attraction for physicians of the South.

Wanted — A Man

A man who can find things to be done without the help of a manager and three assistants.

A man who gets to work on time in the morning and does not imperil the lives of others in an attempt to be the first to quit work at night.

A man who listens carefully when he is spoken to and asks only enough questions to insure the accurate carrying out of instructions.

A man who looks you straight in the eye and tells the truth every time.

A man who does not pity himself for having to work.

A man who is cheerful, courteous to everyone and always determined to "make good."

A man who, when he does not know, says: "I don't know," and when he is asked to do anything says: "I'll try."

— Song Book.

Medical District Meetings
October 22-26, 1951

Dr. William C. Roberts of Panama City, Chairman of Council, has announced that the programs for the four annual Medical District Meetings are now complete. These programs, scheduled for October 22-26, have been developed by Dr. Roberts with the assistance of the eight councilors and the secretaries of the cooperating county medical societies.

Medical District Meetings are designed to enable members to meet and hear Association officers without being required to travel great distances and without having to be away from their practices for extended periods. The scientific program of each meeting has been planned to be sufficiently diversified to be of value to general and specializing practitioner alike.

Following the scientific program, officers of the Association will present pertinent and interesting information at each of the meetings. Association officers on the program include Drs. David R. Murphey, Jr., president; Robert B. McIver, president-elect; Samuel M. Day, secretary-treasurer and Shaler Richardson, editor of The Journal.

All sessions begin at 2:30 p.m on the days indicated on the program below. At 5:45 p.m. refreshments will be served by the host societies. Dinner will follow at 6:30. Printed programs will be mailed to all members of the Association prior to the meetings.

Medical public relations will be the subject for discussion at the evening session beginning at 7:30 p.m. Dr. Eugene B. Maxwell, chairman of the Committee on Public Relations, will preside. Association members and members of the Woman's Auxiliary are urged to attend.

Scientific Assemblies — Four Medical Districts

Monday, October 22, 1951

Pensacola - A

San Carlos Hotel

Address of Welcome, Lee Sharp, President, Escambia County Medical Society

"Gynecological Causes of Pelvic Pain," Joseph W. Douglas, Pensacola

"Common Pediatric Emergencies," William F. Humphreys, Jr., Panama City

Wednesday, October 24, 1951

Bradenton-Sarasota - C

Sarasota Bay Country Club

Address of Welcome, Roderic O. Jones, President, Manatee County Medical Society and Sherrel D. Patton, President, Sarasota County Medical Society.

Part I, "Management of Acute Extremity Injuries," and Part II, "Preventative Orthopedics in the Teen Ages," Donald W. Hedrick, Tampa

"Pitfalls in Modern Therapy," Eugene D. Liddy, Jr., Sarasota

Thursday, October 25, 1951

Vero Beach - D

Driftwood Hotel

Address of Welcome, Erasmus B. Hardee, President, Indian River County Medical Society

"Surgical Treatment of Ulcerative Colitis," Marvin G. Flannery, Miami

"The Hazards of Hormone Therapy," Scottie J. Wilson, Ft. Lauderdale.

Friday, October 26, 1951

Orlando - B

Orange Court Hotel

Address of Welcome, Fred Mathers, President, Orange County Medical Society

"Common Hematological Problems and Their Treatment," Herbert A. King, Daytona Beach

"Proctologic Problems of Interest to the General Practitioner," John J. Cheleden, Ocala

Florida Legislature

During the 1951 session of the Florida State Legislature, your Committee on Legislation and Public Policy was concerned primarily with five amendments to certain sections of the Medical Practice Act. These proposed amendments were sponsored by the State Board of Medical Examiners. They were drafted by Mr. Fred M. Burns, Assistant Attorney General, in consultation with our legislative counsel, the law firm of Messer and Willis, Tallahassee.

These measures, known as House Bills 90-95, passed both houses with no vocal opposition and only two negative votes in each house on the final passage of any of the bills. They became laws without the governor's approval on May 9, effective July 1, 1951.

An added amendment to the Medical Practice Act, House Bill No. 579, also was introduced. The State Board of Health, which is charged by law with the enforcement of the Medical Practice Act (Laws of Florida — Acts of 1945), desired clarification of the section dealing with registration with the State Board of Health. Your committee found nothing objectionable in the provisions of this measure as introduced and passed.

In addition to the amendments, two new laws were enacted which are intended to facilitate the activities of the Medical Examining Board. These were also carefully followed to passage by both houses and enactment into law.

The foregoing constituted the legislation in which we were actively interested. As in previous sessions numerous measures were introduced in which the medical profession was concerned in some degree. Most of these were desirable, or at least relatively harmless. Some few were questionable, but fortunately, for one reason or another, failed to pass.

Considerable time and much tedious labor were devoted to "watch-dog" activities. All bills introduced were carefully checked by title. All those which had any remote possibility of containing sections which we should examine were read thoroughly.

Two bills in which we had keen interest, and which eventually became laws, were the Nurses Practice Act and the Physical Therapist Practice Act. Both these measures had rather rough opposition and were subject to copious amending, but eventually became laws in forms reasonably acceptable to all concerned.

The Nurses Practice Act in particular is still under study for interpretation and clarification. Dr. Samuel M. Day, Secretary-Treasurer of the Association, is cooperating with the Nurses Board to arrange a conference of representatives from the State Board of Nurse Registration and Nursing Education, State Board of Medical Examiners and the Association in order to attempt to arrive at understanding and mutual agreement on questionable passages. All conclusions of the group, of course, will be subject to interpretation and ruling by the Attorney General.

In addition, the State Department of Education, under the direction of Hon. Thomas D. Bailey, Superintendent, is setting up a State Advisory Committee on practical nurse education. Some ten organizations, including the Florida Medical Association, have been asked to name representatives to serve on this Committee.

Plans to introduce early in the session a bill which would prohibit naturopaths from practicing materia medica and prescribing hypnotic and narcotic drugs were reconsidered. Acting on the advice of our legislative consultant, this obviously controversial measure was deferred until all other bills which we were sponsoring had become laws. This caused sufficient delay so that no bill of this nature was introduced until late in the session when prospects for securing passage of controversial measures were not too favorable. Two such bills eventually were introduced into the Senate, but on advice of friends and staunch supporters in the Legislature, they were withdrawn. Possibility of passage of these bills was extremely slight, and we chanced losing much of the good will which has been so carefully developed and preserved during this and past sessions.

Our friends among the legislators do not question the wisdom of taking dangerous drugs out of the hands of inadequately trained persons. They do believe, however, that proposed measures of this type are likely to be misunderstood both by members of the Legislature and the general public. They advise and recommend that such proposed legislation be preceded by a dignified, factual, "grass roots" educational campaign between sessions of the Legislature.

The wisdom and necessity of an Office of Information in Tallahassee during the legislative session was again evident. Also re-emphasized was the value of close coordination and cooperation between this office and the committees on legislation in the county medical societies. Local

societies are the true foundations of sound legislative programs. Senators and Representatives desire to know the opinions of their doctors on matters pertaining to health and medicine.

Our open and above-board methods in legislative matters, as in all other activities of the Association, have produced respect and confidence in the medical profession among the law-makers. However, it will take only a small amount of neglect or a suspicion of "those politicians" attitude to have this confidence disappear. Sound, constructive legislative procedures call for honest and sincere year-round efforts every year by every member of the Association.

With few exceptions, the legislators are conscientiously and honestly trying to do a good job. Each is more likely to continue to try to do so, and will unhesitatingly come to his doctor of medicine for advice on health measures, if he knows that you sincerely appreciate his efforts.

Your chairman spent the major part of the entire session in Tallahassee. He is glad to be able to serve his state and his profession, although there are times when the sacrifice of time and effort is considerable. His contribution of the last session would have been considerably reduced had it not been for the invaluable assistance of Mr. Tom Stallworth of Florida Blue Shield and our legislative consultant, Mr. Ben Willis. I want to express my personal appreciation to both men, to our many friends in the Legislature, to committee chairmen and others in the county medical societies and to the effective and indispensable ground work between sessions by the Bureau of Public Relations of the State Association.

Government, be it local, state or national is good, bad or indifferent in direct proportion to the amount of interest and activity displayed by every citizen — including the medical profession.

Eugene G. Peek, Sr., Chairman

Committee on Legislation and Public Policy

ENACTING CLAUSES OR SYNOPSES OF CERTAIN LAWS PASSED BY THE 1951 LEGISLATURE

AMENDING MEDICAL PRACTICE ACT

Relating to the Approval and Classification of Medical Schools and Colleges, and of Hospitals, by the Board of Medical Examiners — Chapter 26548, No. 69, H.B. No. 91: authorizes the Board to pass upon the good standing and reputability of any hospital, as well as medical schools, in considering the standard of training sufficient to be recognized by the Board when considering medical examinations.

Relating to Applications to Take Examinations Given by the Board of Medical Examiners and the Qualifications Necessary to Admit Applicants to Such Examinations — Chapter 26549, No. 70, H.B. No. 90: specifies that applicants for examination by the Board must be citizens of the United States. Autborizes the Board to admit to examinations graduates of non-approved medical schools and colleges who have subsequently taken training sufficient, in the opinion of the Board, to bring the applicants medical education up to a standard equivalent to that of graduates of approved medical schools and colleges.

Relating to Certain Limitations upon the Practice of Medicine in the State — Chapter 26551, No. 72, H.B. No. 94: limits to three (3) years the period during which a resident physician, assistant resident physician, intern or assistant to a licensed physician may practice without becoming duly licensed by the Board.

Relating to Revocation, Suspension, Annulment and Denial of Licenses to Practice Medicine — Chapter 26552, No. 73, H.B. No. 93: clarifies the procedure to be followed by the Board in revocation cases, specifies the powers of the Board in conduction of hearings, explains the requirement for review of Board orders by the circuit court and rights of appeal. Adds three (3) new grounds for revocation, suspension, annulment or denial of licenses: (1) immoral or unprofessional conduct, (2) maintenance of professional connection or association with another who continues to violate the Act or the rules and regulations of the Board, after 10 days notice in writing, (3) where insanity has been adjudged by the proper courts and so long as the adjudication remains in full force and effect.

Relating to the Amount of Fees to Be Paid in Connection with Applications to Take the Medical Examinations —Chapter 26553, No. 74, H.B. No. 92: sets the fee for applicants for license by examination at $50.

Relating to Recording of Licenses to Practice Medicine and Registration with the State Board of Health — Chapter 26772, No. 293, H.B. No. 579: requires tbat licenses shall be recorded with the clerk of the circuit court witbin sixty days after the date of such license, or the date of recertification by the board of medical examiners.

NEW LAWS AFFECTING THE STATE BOARD OF MEDICAL EXAMINERS

Providing a Method for Proving That a Person Practicing Any of the Healing Arts Is or Is Not Duly Licensed —Chapter 26550, No. 71, H.B. No. 96: provides that the properly executed certificate of the various healing arts boards that a person is or is not licensed shall be prima facie evidence of sucb fact. This is intended to simplify establishment of such fact in court cases in whicb a license is a matter of dispute.

Authorizing the State Board of Medical Examiners to Appoint or Employ an Assistant Secretary or Secretaries Who Need Not Be Licensed Physicians nor Members of the Board — Chapter 26554, No. 75, H.B. No. 95.

OTHER PERTINENT LEGISLATION

Nurses Practice Act — Chapter 26797, No. 318, H.B. No. 302: an act regulating the practice of nursing for hire or gain, creating the Florida State Board of Nurse Registrations and Nursing Education, defining its powers and duties, abolishing the State Board of Examiners for Nurses, transferring its rights, powers and duties, providing for the transfer of funds, prescribing fees, defining certain misdemeanors and providing penalties for violations thereof; repealing Chapter 464, Florida Statutes 1949 and all Acts amendatory thereto.

Physical Therapists Practice Act — Chapter 26925, No. 446, H.B. No. 8: provides for examination of applicants by the Board of Medical Examiners providing the applicant holds a certificate of proficiency in specified basic sciences from the Board of Examiners in Basic Sciences. The law does not prohibit an unregistered pbysical therapist from practicing. It merely prohibits him from claiming that he is a "registered physical therapist" or "R.P.T."

Relating to Medical School Education in the State of Florida—Chapter 26763, No. 284, S.B. No. 71: an act authorizing the Board of Control to pay to the first approved and accredited medical school established in Florida the sum of $3000 per year for each qualified Florida student enrolled.

Amending Florida Statutes Relating to Dead Bodies—Chapter 26724, No. 245, S.B. No. 325: prohibiting trafficking in dead human bodies except by proper authorities for use in scientific research and instruction in specified types of educational institutions.

An Act Empowering the Board of County Commissioners of Each County To Give Dead Human Bodies, Unclaimed by Relatives Within Ten Days After Death, to Various Schools and other Institutions for Educational and Research Purposes (within or without the state)—Chapter 26798, No. 319, S.B. No. 326.

Relating to Furnishing Reports of Mental and Physical Examinations of Persons by Doctors and Other Practitioners of the Healing Sciences — Chapter 26684, No. 205, H.B. No. 105: an act requiring physicians to furnish copies of a physical or mental examination upon request by the patient or his representative. Such reports are not to be furnished to any other person except on written authorization of the patient, provided however that any person, firm or corporation procuring such examination with the patient's consent, or examination by court order, shall not be required to obtain the patient's permission.

Requiring the Compulsory Isolation and Hospitalization of Certain Persons Infected with Tuberculosis—Chapter 26828, No. 349, S.B. No. 385: designates tbe procedure for compulsory isolation and treatment of infected persons, considered as endangering the health of other persons, when said infected persons refuse to take treatment voluntarily.

Amending Florida Statutes Relating to the Compulsory Treatment of Persons Afflicted with Tuberculosis—Chapter 26885, No. 406, H.B. No. 799; authorizes and directs that adequate facilities be provided for compulsory isolation and treatment of tuberculosis patients.

An act designating that the previously authorized state hospital for alcoholics shall be located in Highlands county—Chapter 26817, No. 254, H.B. No. 254.

Florida Cancer Council Recommends Discontinuation of Physicians' Fees For State Aid Cancer Cases

The Florida Cancer Council had its second meeting in Tampa on Aug. 24, 1951. This Council is composed of two physicians representing the Committee on Cancer Control of the Florida Medical Association; Dr. Frazier J. Payton of Miami and Dr. George W. Morse of Pensacola. The American Cancer Society, Florida Division, is represented by Dr. Ashbel C. Williams of Jacksonville and Dr. C. Frank Chunn of Tampa. The American College of Surgeons is represented by Dr. Duncan T. McEwan of Orlando. The Florida State Board of Health is represented by Drs. Wilson T. Sowder and L. L. Parks, Jacksonville.

The primary purpose of the meeting at this time was to consider and make recommendations concerning the payment of fees to physicians for services rendered State Aid Cancer Cases under the Cancer Control Program of the State Board of Health.

After considerable discussion and consideration of the many problems that this subject presents, the Florida Cancer Council passed unanimously the following resolution:

> Since the State Board of Health is having to operate the overall State Health Department Program for the next two years on a smaller appropriation than it did during the last year, the Cancer Control Division will be forced to share its part of the curtailment in funds available for health services.
>
> The Florida Cancer Council recommends that all fees to physicians be discontinued effective Oct. 1, 1951 with the exception of the payment of fees to radiologists and anesthetists, as outlined in the Cancer Manual, at the 50 per cent reduction fee as has been done since Oct. 23, 1950. The radiologists and anesthetists are being requested to work out and recommend a suitable fee schedule at their earliest opportunity.

It was noted that the Florida Pathological Society has already discontinued acceptance of fees for tissue examinations for state aid cancer cases that are indigent.

The Florida Cancer Council further stated that since the subject of Cancer Control Program fees has been the subject of considerable controversy, that this subject should again be brought to the attention of the House of Delegates by the Association's Committee on Cancer Control, after clearing through the Board of Governors' Sub-committee on Review of Fee Schedules.

The Concer Control Program was first considered by the Florida Medical Association in 1944 and was approved. The Board of Governors approved the Cancer Program in 1947 and it was also approved by the House of Delegates that same year.

Following the action and recommendations of the Cancer Council at the Tampa meeting a letter has been sent to the secretary of each of the County Medical Societies. This letter stated that the fees of all physicians for services rendered to state aid cancer cases will be discontinued by the Florida State Board of Health effective Oct. 1, 1951. An exception was made for the radiologists and anesthetists whose fees will be continued temporarily until these specialists have an opportunity to work out a suitable plan.

YOUR BLUE SHIELD

Blue Cross Broadens Benefits

Effective Nov. 1, 1951, four of the benefits covered by the Florida Blue Cross Contract will be increased at no increase in membership fees for Blue Cross members who were originally enrolled through group membership.

Three of the benefits which are to be increased are electrocardiograms, basal metabolism tests and electroencephalograms, each of which presently carries a $10 maximum payment for each hospital admission. After November 1, Blue Cross will pay the full charges of participating hospitals for these services.

The fourth benefit to be increased will affect Blue Cross members who are hospitalized in hospitals which are not participating in the Florida Plan or any other Blue Cross Plan, but which are approved by the American Medical Association. Allowance for care in non-participating hospitals is presently $10 for a one-day stay, $17 for a two-day stay and $7 a day thereafter for the number of days available to the subscriber during the contract year. The new allowance will be $20 for the first day, $28 for the first two days and $7 a day for each day thereafter for the number of days available to the member during the contract year.

This increase in benefits is in line with the non-profit principle of Blue Cross operation, under which all monies received from subscription fees are used for the hospital care of members, the operation of the Plan and the building up of adequate reserves to assure financial stability for the Plan. All reserves over and above the amount necessary for financial stability are returned to the members in the form of increased benefits. Since

the headquarters of the Plan is now housed in one building, efficiency of operation has improved and operating expenses have been lowered, thereby making possible an increase in benefits.

As stated above, for the present time, the broadened benefits will be applicable only to those members who were originally enrolled in Blue Cross through group membership. Members who were enrolled under non-group (individual) membership, will be notified at a later date of the changes in benefits under their Blue Cross contracts.

An increase in Blue Shield benefits is presently under study and consideration and will be announced in the near future.

STATE BOARD OF HEALTH

Malaria Among Korean Veterans Returning to Florida

Significant numbers of Armed Forces personnel returning from Korea are experiencing attacks of vivax malaria after their return to this country, and while they are not under military supervision, i.e., on leave or after separation. Presumably these infections were acquired approximately one year ago, symptoms manifesting themselves now because of the effects of suppressive medication. Four such cases have been reported this year in Florida.

Physicians of Florida are being advised to suspect malaria among patients presenting suggestive signs and symptoms and who have been in Korea during the last year. Definitive diagnosis should be based on the demonstration of malaria parasites in the blood smear. The chances of discovering parasites are much better in thick blood films than in thin ones. The State Board of Health is desirous of collecting all positive blood smears found by physicians. Where the blood findings are positive, controversial, or uncertain the slides will be sent to the National Depository for Malaria Slides for further examination by non-governmental consultants.

For this purpose clinical laboratories are asked to send to the Bureau of Laboratories, Jacksonville, all slides found positive or suspicious for malaria. These will be sent on to the National Depository for Malaria Slides.

Treatment with modern antimalarials now available (chloraquine, quinacrine, pentaquine, etc.) will alleviate symptoms promptly. Experience of the Army in Korea seems to show that chloraquine (aralen) is the drug of choice. Certain of the cases receiving complete courses of these drugs will remain free from malaria, but it is probable that others will relapse after weeks or months. Patients should be told of this possibility and advised to seek medical treatment again if symptoms recur. The likelihood of clinical reactivation becomes less with the passage of time; relapses are rare after the second or third attack.

To prevent the spread of malaria from these individuals, cases should be reported to the county health officer promptly so that residual insecticides may be applied to houses within a mile of parasite-positive persons if Anopheles mosquitoes are known to be prevalent in the area.

There have been only five laboratory proven cases of malaria reported to the State Board of Health this year and four of these were veterans from Korea. The fifth case was a visitor from Cuba. Malaria is no longer a health problem in Florida and efforts are being made by the State Board of Health to help keep Florida free of this disease.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. Lillian E. C. Mark (Mrs. Henry Mark) and Henry Mark, D.D.S., of Jacksonville announce the birth of a daughter on Aug. 7, 1951.

Dr. and Mrs. Paul F. Hutchins of Jacksonville announce the birth of a daughter, Pamela Simpson, on Aug. 23, 1951.

Marriages

Dr. Leon H. Mims, Jr., and Miss Ruth Welsh, both of Miami, were married on July 29, 1951.

Deaths — Other Doctors

Ilderton, John A., Yemasee. S. C. ..... Nov. 4, 1946
McCorkle, Robert L., Atlanta, Ga. ..... June 15, 1947
Lott, Walter M., Nashville, Tenn. ..... Feb. 15, 1948
Caldwell, Herbert, Hampton Beach, N. H. ... Aug. 23, 1951
Johnson, Raymond L., Waycross, Ga. ..... Sept. 1, 1951
Sayles, Charles F., Little Switzerland, N. C. .. Sept. 2, 1951

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bistowish, Joseph M., Jr., Tallahassee
Bolker, Abraham, Miami
Hallstrand, David E., Tallahassee
Yount, Harold A., Statesville, N. C.

STATE NEWS ITEMS

President David R. Murphey, Jr., and Dr. Eugene B. Maxwell, Chairman of the Association's Committee on Public Relations, were guest speakers at the regular monthly meeting of the Marion County Medical Society on August 14 in Ocala.

A revised list of "Sources of Motion Pictures on Health" has been prepared by the Committee on Medical Motion Pictures of the American Medical Association. This new mimeographed list includes 9 pages of addresses of the major loan and rental libraries, the state health departments' film libraries and references to printed lists and catalogs. Copies are available from: Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10, Ill.

Dr. Sidney Davidson, Lake Worth, recently spoke on "Drug Addiction" at the Officers' Chapter of Women of the Moose in West Palm Beach.

Dr. Murray D. Sigman of West Palm Beach recently gave an illustrated talk on cancer at a meeting of the West Palm Beach Painters' Local 452, A. F. L.

Dr. George F. Hieber of St. Petersburg, president of the Florida Allergy Society, recently addressed the local Rotarians concerning some of the causes and treatments of allergic conditions.

Dr. J. Sudler Hood of Clearwater has returned to his practice following a postgraduate course at Harvard Medical School.

Dr. Odis G. Kendrick, Sr., of Tallahassee was recently honored by medical colleagues and friends of the community for 35 years of service.

Dr. Elwyn Evans of Orlando has been appointed chairman of the Florida branch of the National Doctors Committee for Improved Federal Medical Services by Dr. Robert Collier Page, national chairman. The Committee is sponsoring adoption of the Hoover Commission plans for reorganization of the Federal government.

Dr. Albert V. Hardy of Jacksonville, Director of the Florida State Board of Health's Bureau of Laboratories, has returned to his post following a tour of duty in Korea. Dr. Hardy has been on a 3½ months leave of absence while serving with the armed forces epidemiological board. He has been assisting in setting up a control and research program for dysentery.

Dr. Franz A. Stewart, Jr., editor of the Dade County Bulletin, presented the story of the medical practitioners' code before a recent meeting of the Greater Miami Chapter of the American Institute of Architects.

Dr. Lloyd J. Netto of West Palm Beach discussed the importance of early diagnosis in cancer at recent luncheon meetings of the Rotary and Lions Clubs. An American Cancer Society film was shown in conjunction with Dr. Netto's talks.

Dr. Luther W. Holloway of Jacksonville has returned to his practice following a tour of the West which included visits to several clinics at the Children's Hospital of Denver.

Dr. Eaton G. Lindner and Dr. John N. Moore, both of Ocala, were signally honored recently for long and meritorious service. Each doctor was presented a silver loving cup by Dr. Eugene G. Peek, Sr., on behalf of Dr. Richard C. Cumming who donated the cups. The occasion was a combined meeting of the Marion County Medical Society and the staff of the Monroe Memorial Hospital.

Dr. Edward E. Cava of Miami, has recently returned to his practice after taking a two weeks course in electrocardiography and cardiology at the Cook County Graduate School of Medicine, Chicago. He also visited the Mayo Clinic, Rochester, Minn.

Dr. John M. Schultz of Miami is in residency at Frances Delafield Hospital, Columbia Presbyterian Medical Center, New York, until July, 1952.

Dr. Frank G. Slaughter of Jacksonville, author and surgeon, has released through his publishers his latest novel, "The Road to Bithynia," based on the life of St. Luke "the beloved physician."

The story deals with Luke's search for peace in the years immediately following the Crucifixion. Notable characters include Peter, Herod, Paul and Stephen. Interwoven is the tender love story of the beautiful Thecla, one of Paul's followers. Dr. Slaughter refers to his novel as fictional biography.

Dr. John A. Simmons, Arcadia, recently was a guest speaker at a meeting of a local Kiwanis Club. Dr. Simmons reviewed hospital activities in DeSoto County and the present outlook for additional hospital facilities.

Dr. Charles L. Farrington, St. Petersburg, has returned to his practice following a trip to Jamaica and the Dutch West Indies. Dr. Farrington was guest speaker at a meeting of doctors on the Indies island of Aruba.

Dr. Paul W. Hughes of Ft. Lauderdale, Director of the Broward County Health Department, was guest speaker at recent meetings of the Rotary Clubs of Hollywood and Dania.

Dr. Hugh A. Carithers of Jacksonville has returned to his practice following a trip to Saluda, N. C., where he served as a member of the faculty for the Pediatric Seminar held in that city in July.

Various phases of the work of Hope Haven Hospital were recently explained to members of the Meninak Club by Drs. A. Judson Graves, John F. Lovejoy, James C. Lanier and Frederick Waas, all of Jacksonville.

Dr. Benjamin H. Sullivan, formerly of Jacksonville, announces the opening of his offices for the practice of neurological surgery at 503 Rutland Building, St. Petersburg.

Dr. Bernard J. McCloskey, Jacksonville, will be absent from his practice during the week of October 15-20 while attending a course in allergy at the University of Pittsburg, under the direction of Dr. Leo Criep.

COMPONENT SOCIETY NOTES

Dade

Members of the Dade County Medical Association at their regular monthly meeting on September 4 were privileged to hear a symposium on car pulmonale. The program was conducted by Drs. Morris M. Dick, George Baum, Jack Reiss and Sidney Fox.

Duval

The Duval County Medical Society will resume its regular monthly meetings at the Sellers Auditorium, October 2 at 8:15 p.m.

Leon-Gadsden-Liberty-Wakulla-Jefferson

At the recent quarterly meeting of the Leon-Gadsden-Wakulla-Jefferson County Medical Society cases of scurvy found in Florida were discussed by Dr. Joseph Bistowish, county health officer.

Marion

The Marion County Medical Society held its regular monthly meeting on August 14 at the Monroe Memorial Hospital meeting jointly with the Hospital staff. Guest speakers were Dr. David R. Murphey, Jr., of Tampa, F.M.A. president, and Dr. Eugene B. Maxwell, also of Tampa, Chairman of the Association's Committee on Public Relations.

Pinellas

The regular monthly meetings of the Pinellas County Medical Society were discontinued during the summer months. Regular meetings will resume on September 10 at the Detroit Hotel, St. Petersburg.

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Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

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OBITUARIES

Jay Allen Powell

Dr. Jay Allen Powell of West Palm Beach died at his home on July 2, 1951, after a long illness. He was 57 years of age.

An Alabamian, Dr. Powell was born at Dothan, Ala., on Oct. 2, 1893. He received the degree of Doctor of Medicine from the University of Oklahoma School of Medicine in 1918. After interning at The New York Polyclinic, he pursued postgraduate work at St. John's Long Island City Hospital, St. Mary's Hospital for Children, New York Lying-In Hospital and Cook County Hospital in Chicago.

In 1920, Dr. Powell began the practice of medicine in West Palm Beach and continued to practice medicine and surgery there until ill health forced his retirement in 1945. He was a charter member of the staff of the Good Samaritan Hospital. For more than a quarter of a century he was especially active in work for the needy and is credited with having performed more than 10,000 operations without remuneration. He served the First Methodist Church in various official capacities and was a member of a number of Masonic bodies, including the Mahi Shrine Temple at Miami. Long active in religious and civic affairs, he was treasurer and a member of the advisory board of the Salvation Army.

A charter member and past president of the Kiwanis Club, Dr. Powell was keenly interested in the Kiwanis Clinic for Underprivileged Children, of which he was a founder and for many years directing head. For this outstanding civic and professional activity he was awarded the Civic Achievement Medal of the Civitan Club of West Palm Beach in 1929. In 1946 he was presented the Legion of Honor of Kiwanis International in further recognition of his achievements as a Kiwanian and citizen.

Dr. Powell was a past president of the Palm Beach County Medical Society. He was for twenty-five years a member of the Florida Medical Association, holding honorary status the last four years of his life. He also held membership in the American Medical Association and was a fellow of the Southeastern Surgical Congress.

In 1923 Dr. Powell was married to Miss Emily Gertrude Gill of Petersburg, Va., who survives him. Other survivors include a sister, Mrs. H. A. Lee of Marianna, and a brother, Herbert F. Powell of West Palm Beach.

Gerald W. Jones

Dr. Gerald W. Jones of Orlando died at his home on June 5, 1951, following a brief illness with chorionic epithelioma. He was 32 years of age.

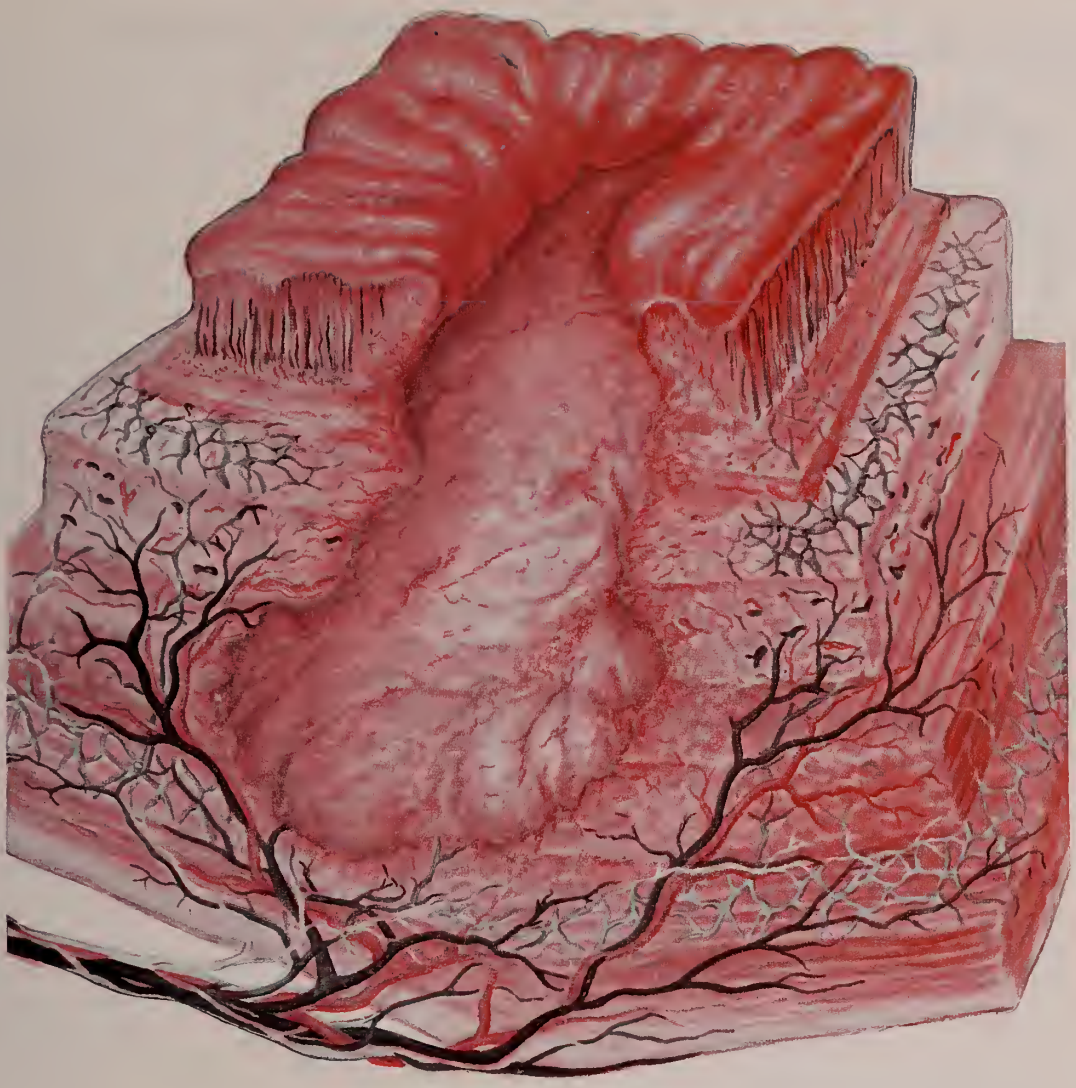
The son of Dr. and Mrs. N. C. Jones, Dr. Jones was born in Daytona Beach on Oct. 11, 1918, and came to Orlando to live at the age of 2 years. Upon graduation from the Orlando High School in 1936, he attended Emory University in Atlanta, Ga. In 1940, he was awarded the degree of Bachelor of Science in Medicine at that institution and in 1943, the degree of Doctor of Medicine.

After completing an internship at Emory University Hospital, Dr. Jones became resident physician at the Orange Memorial Hospital in Orlando in January 1945. He remained there until he entered the Medical Corps of the Army of the United States in July 1945. In November 1946 he was discharged with the rank of captain.

Following his discharge from the Army, Dr. Jones entered the private practice of medicine in Orlando. He was at first associated with Dr. Horace A. Day and later opened his own office. In 1947 he became a member of the staff of the Orange Memorial Hospital. Locally, he was also a member of the Orlando Medical Study Club, the Orlando Executive Club, the Chamber of Commerce and the First Methodist Church. He was a member of the Alpha Tau Omega social fraternity and the Theta Kappa Psi medical fraternity.

Dr. Jones was a member of the Orange County Medical Society, of which he was secretary at the time of his death. He also held membership in the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Fay M. Jones; one son, Gerald W., Jr.; one daughter, Sarah Ann, and the parents, all of Orlando.



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A MOST CORDIAL WELCOME awaits physicians of the South attending the Dallas meeting which will consist of forty-seven half-day sessions presented by the twenty-one sections embracing every phase of medical practice. In addition to these activities there will be two general sessions, the annual dinner of the association, and outstanding scientific and technical exhibits.

THE COMPLETENESS of the program and the excellence of the exhibits will again make this meeting of the Southern Medical Association the outstanding general medical meeting of the year for physicians of the South.

REGARDLESS of what any physician may be interested in, regardless of how general or how limited his interest, there will be at Dallas a program to challenge that interest and make it worthwhile for him to attend.

MEMBERS of state and county medical societies may attend. Eligible physicians, members of state and county medical societies in the South can be and should be members of the Southern Medical Association. The annual dues of $10.00 include the Southern Medical Journal, a journal most valuable to physicians of the South, one that each should have on his reading table.

SOUTHERN MEDICAL ASSOCIATION
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Ernest Ezra Nunnery

Dr. Ernest Ezra Nunnery of Everglades died on May 2, 1951. He was 66 years of age. Interment took place at Flagler Memorial Cemetery in Miami.

Born in 1884, Dr. Nunnery was educated in Tennessee. At the age of 15 years he was graduated from the Lexington Baptist College in Lexington as valedictorian of his class. He was a graduate of the University of Tennessee and salutatorian of his class. He then received the degree of Doctor of Medicine in 1907 from the University of Nashville Medical Department. At the age of 21, he began the practice of medicine in Jackson, Tenn.

At the time of his death Dr. Nunnery was physician in charge of the Juliet C. Collier Hospital in Everglades. He was a Mason and a Shriner, held life membership in the Knights of Pythias, and was a member of the Baptist Church.

During the forty-four years that he practiced medicine, Dr. Nunnery saw varied service. He was a surgeon in World War I, holding the reserve rank of lieutenant colonel. During World War II he practiced in the Veterans Hospital in Wichita, Kan. He served several years in the United States Public Health Service. In Panama, he was chief of staff in Cristobal Hospital for six years and for more than three years served as district physician in Pedro Miguel. For brief periods he practiced in Shanghai, China, and Liverpool, England.

Dr. Nunnery was a member of the Lee-Charlotte-Collier-Hendry County Medical Society, the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Jo M. Nunnery of Everglades, and one son, Jack Ernest Nunnery of New Orleans.

Everett Edmunds Howard

Dr. Everett Edmunds Howard of Gainesville died on May 14, 1951, following an operation. He was 64 years of age.

Born on April 20, 1887 in Alvin, Ill., Dr. Howard received the degree of Doctor of Medicine in 1913 from the University of Louisville School of Medicine. After serving internships in the Norton Memorial Infirmary and the Louisville City Hospital, he continued postgraduate study

in the Presbyterian Hospital in New York and the Cook County Hospital in Chicago.

A veteran of World War I, Dr. Howard for thirty years engaged in the general practice of medicine and surgery in Peoria, Ill., and served on the staffs of the Methodist and Proctor Memorial hospitals of that city. In 1949 he came to Florida, locating in Gainesville. He served on the staff of the University of Florida Infirmary and was acting physician in charge at the time of his death.

At various times Dr. Howard had been a member of the Illinois, Kentucky and Tri-State medical societies. He was a member of the Alachua County Medical Society, the Florida Medical Association and the American Medical Association.

Dr. Howard is survived by his widow and two children.

Leon Herbert Martin

Dr. Leon Herbert Martin of Okeechobee died in the McDill Field Hospital at McDill Air Base, Tampa, on May 17, 1951, after several months' illness. He was 61 years of age. Interment took place in the family plot at Enterprise, Ala.

A native of Alabama, Dr. Martin was born in Enterprise in 1889. He received the degree of Doctor of Medicine from the Barnes Medical College in St. Louis in 1910. A general practitioner, he practiced in Texas, Alabama and Miami before locating in Ft. Pierce in 1936. He conducted his practice there until he entered the Air Force Medical Corps in World War II. At that time, he was a retired major, having served with the United States Army Medical Corps during World War I. While serving in Europe in that war, he was awarded the Silver Star. Upon receiving disability retirement in World War II, he returned to Ft. Pierce and practiced for a time. Later, he went to Okeechobee to practice, but soon afterward, in December 1950, his illness made hospitalization necessary.

Dr. Martin was a member of the St. Lucie-Okeechobee-Martin County Medical Society, the Florida Medical Association and the American Medical Association.

Surviving are one daughter, Mrs. E. G. Gibson of Miami; one son, Don Martin of Ft. Pierce; five brothers, Don, Richard, John and Edwin Martin of Enterprise, and Virgil Martin of Columbus, Ga.; and one sister, Mrs. Lucy Capps of Enterprise.

Advertisement



From where I sit *by* Joe Marsh

Skip Makes a Slip

Miss Gilbert, the teacher, was telling me how Skip Lawson almost went to sleep in her physics class.

She saw him nodding and—since they were studying electricity—said in a loud voice: "Maybe MR. LAWSON will explain to us what electricity is." Skip started up, looked around wildly, and blurted out,"Gee! I used to know, Miss Gilbert, but somehow I forgot."

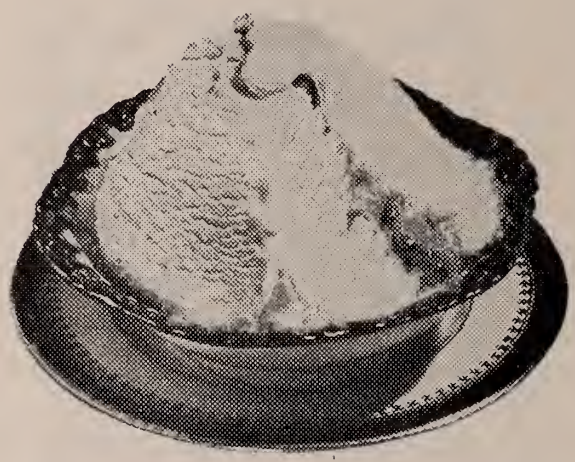
"What a loss to science!" sighs Miss Gilbert. "No one to this day knows what electricity really is, and here we have a genius who could explain it—but forgot!"

From where I sit, I hope this taught Skip that you're better off if you admit you *don't* know all answers. Some grownups haven't learned that yet—like the ones who are always telling other people how a man should practice his profession, or what beverage is "good" for a person. I like a temperate glass of beer, myself, but if you prefer buttermilk I won't argue. I've seen too many "know-it-alls" turn out to be wrong!

Joe Marsh

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The Job Ahead

It is a delicate task for the leaders of the A. M. A. to say "Thank you" to those who have worked so diligently to secure the success American medicine has achieved through its educational campaign, and through the indefatigable efforts of those who carried the campaign to the various organizations to which they belong, without giving the impression that "the job is done." It is vitally necessary that we realize that in shifting position we do not abandon the post.

"Though the broad National campaign will come to a close at the end of the year, at which time the House of Delegates of the American Medical Association has requested that a simple 'holding action' be instituted, with a nucleus campaign staff held ready to meet at its incipience any further threats of socialistic moves against medicine, a real job remains to be done."

So stated John W. Cline, M.D., President of the A. M.A., who is aware that vigilance is necessary because a further threat of socialization might occur at any time this year or next. The Woman's Auxiliary may be asked at any time to aid, as it has in the past, when medicine faced its fight for survival.

We now know that we must increase our organization in strength and numbers and continue

our work in education. It has become obvious that those who would socialize the medical profession will reach into every business, profession and organization they can approach in order to popularize the idea of subsidization and dependence. They will use the weapons of flattery, thousands of propaganda workers, and humanitarian sounding appeals for extended aid to the aged, young, and other causes which have popular appeal.

As Doctor Cline pointed out: ". . . the greatest assistance we have had in the National campaign has been the strong position held by other organizations standing with us against socialized medicine. The Auxiliary has been of tremendous help in securing this 'grass roots' support, and it is important that that work be continued."

It is important too, that we use the knowledge gained in this work to aid other groups in recognizing dangerous trends toward socialization which are continually making inroads in our everyday life and by so doing, prove that our interest is not a self-centered one, but motivated by a board sense of responsibility toward our nation as a whole.

Mrs. C. Robert DeArmas
President.

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BOOKS RECEIVED

REVIEW OF PHYSIOLOGICAL CHEMISTRY. By Harold A. Harper, Ph.D. Ed. 3. Pp. 260. Price, $3.50. Palo Alto, Calif., University Medical Publishers, 1951.

Intended as a supplement to the standard texts in biochemistry and as a companion volume for the student in such courses, this third edition of the Review presents the fundamentals of physiologic chemistry with emphasis on the accepted facts and concepts of the subject. A concise presentation of the applied and established principles has been favored over that of the theoretic and controversial.

The author, who is Professor of Biology (Biochemistry) at the University of San Francisco, has drawn much of the material in the book from his lectures in basic science given in conjunction with the graduate training of physicians. It therefore affords an excellent review for the physician preparing for state and specialty boards. In addition, it should aid him in keeping abreast of this rapidly expanding branch of medical science which now contributes much to the understanding and practice of all phases of medicine.

HANDBOOK OF NUTRITION, A SYMPOSIUM. Prepared under the auspices of the Council on Foods and Nutrition of the American Medical Association. Ed. 2. Pp. 717. Price, $4.50. New York, The Blakiston Company, 1951.

This second edition of a standard handbook contains nutritive requirements of man under conditions seldom studied before — those resulting from the war which threw revealing light on man's nutritive processes. Included also is new information on individual nutrients — carbohydrates, vitamins; nutritional needs — in geriatric medicine, in illness and disease; nutritional deficiencies — fat-soluble vitamins, water-soluble vitamins, minerals; and foods and their nutritional qualities — foods of plant origin, of animal origin, and for emergencies.

Long recognized as an authority in the field of nutrition, this book is valuable for physicians, nutritionists, medical students, and other professional groups interested in the subject.

PRACTICAL CLINICAL PSYCHIATRY. By Edward A. Strecker, A.B., A.M., Sc.D., Litt. D., LL.D., M.D., Franklin G. Ebaugh, A.B., M.D., and Jack R. Ewalt, M.D. Ed. 7. Pp. 506. Price, $7.00. New York, The Blakiston Company, 1951.

This seventh edition of a standard text for psychiatrists has been brought completely up-to-date with modern psychiatric teaching and thought. Written by recognized leaders in the field, it is designed not alone for psychiatrists but also for medical students and general practitioners, who, because they treat the vast majority of psychiatric patients, need to keep abreast of modern developments.

Included are the Armed Forces Classification of Mental Disorders and the American Psychiatric Association Classification of Mental Disorders. There is a new section on Support Therapy which outlines effective methods of treating patients requiring treatment less extensive than orthodox analytic procedures. Also, new case histories are included throughout to illustrate the basic principles.

LET'S HAVE HEALTHY CHILDREN. By Adelle Davis, A.B., M.S. Pp. 314. Price, $3.00. New York, Harcourt, Brace and Company, 1951.

Published in late August, this guide to motherhood and child care up through the pre-school age is unusual in many ways, especially in the particular attention it gives to the periods before conception and during pregnancy. Equally useful information is offered in the chapters devoted to rearing a healthy baby.

A nutritionist of wide experience, including many years of working with obstetricians and pediatricians on diet problems, the author presents strong evidence, with case histories and well documented medical references, for her advice concerning sound nutrition.

LET'S COOK IT RIGHT... By Adelle Davis, B.A., M.S. Pp. 626. Price, $3.00. New York, Harcourt, Brace and Company, 1947.

This new, promotion edition of a new kind of cooking guide, for the beginner or the experienced cook, is a companion volume to the author's "Let's Have Healthy Children." Much of the advice in the book on motherhood and child care can be most helpful if implemented with recipes from the cookbook. In presenting 350 basic recipes for preparing every variety of food, and over 3,000 variations of them, Miss Davis gives special attention to meats, not only because they are expensive and a popular food item but also because protein deficiencies are widespread, and, in addition, to vegetables, because they have been robbed of their nutrients during cooking more than any other food.

SPATIAL VECTOR ELECTROCARDIOGRAPHY, CLINICAL ELECTROCARDIOGRAPHIC INTERPRETATION. By Robert P. Grant, M.D., and E. Harvey Estes, Jr., M.D. Pp. 149. Price, $4.50. New York, The Blakiston Company, 1951.

This text simplifies for practitioners and students the problem of reading and interpreting electrocardiograms by the use of vector methods. It is written in simple and nontechnical terms for daily use by those who have had no special training in physics or mathematics. It contains only those theoretic aspects absolutely indispensable for a clear understanding of the clinical application of the electrocardiogram.

The use of vector methods gives simple, accurate and objective interpretations of normalities and abnormalities. When combined with the "pattern" and empiric methods, it makes the interpretation objective rather than intuitive.

The material included covers the ventricular electrocardiogram — a discussion of the QRS and T abnormalities.

NEW AND NONOFFICIAL REMEDIES, 1951. Issued Under the Direction and Supervision of The Council on Pharmacy and Chemistry, American Medical Association. Pp. 782. Philadelphia, J. B. Lippincott Company, 1951.

Included in this annual publication are articles which the Council on Pharmacy and Chemistry of the American Medical Association has found acceptable under its rules through the period ending on Jan. 1, 1951. In this 1951 edition the rules for admission of articles have been modified and reorganized. Certain chapters have been rewritten and new chapters have been added. A standard style for description of included articles has been developed in new monographs and general statements.

Essentially, the book consists of two major divisions: Section A with general statements on broad classifications of preparations, and monographs describing the actions, usage, and dosage of specific articles; and Section B with physical descriptions, tests, and standards for Council accepted drugs for which official standards are not available.

Relationship of Stress to Autonomic Lability

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance. [1,2] Such states may involve any one of the organ systems or several at one time. [1,3] The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifesta-tions	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references 3,4,5,6,7, given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives. [8,9,10.]

1. Ebaugh, F.: Postgrad. Med. *4:* 208, 1948. 2. Wilbur, D.: J.A.M.A. *141:* 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. *42:* 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. *27:* 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. *107:* 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. *58:* 251, 1948.

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GYNECOLOGY—Intensive Course, Two Weeks, starting October 22. Vaginal Approach to Pelvic Surgery, One Week, starting November 5.

OBSTETRICS—Intensive Course, Two Weeks, starting November 5.

MEDICINE—Gastroenterology, Two Weeks, starting October 15. Electrocardiography & Heart Disease, Two Weeks, starting October 22.

DERMATOLOGY—Intensive Course, Two Weeks, starting October 15.

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*Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.



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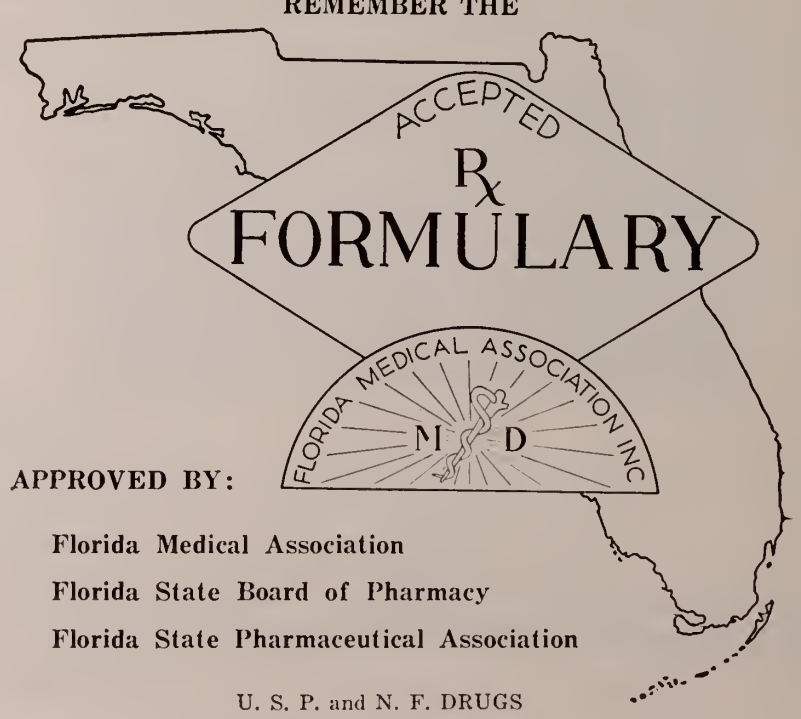
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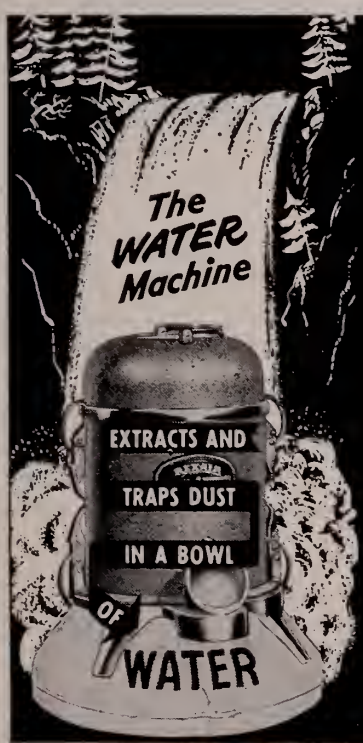
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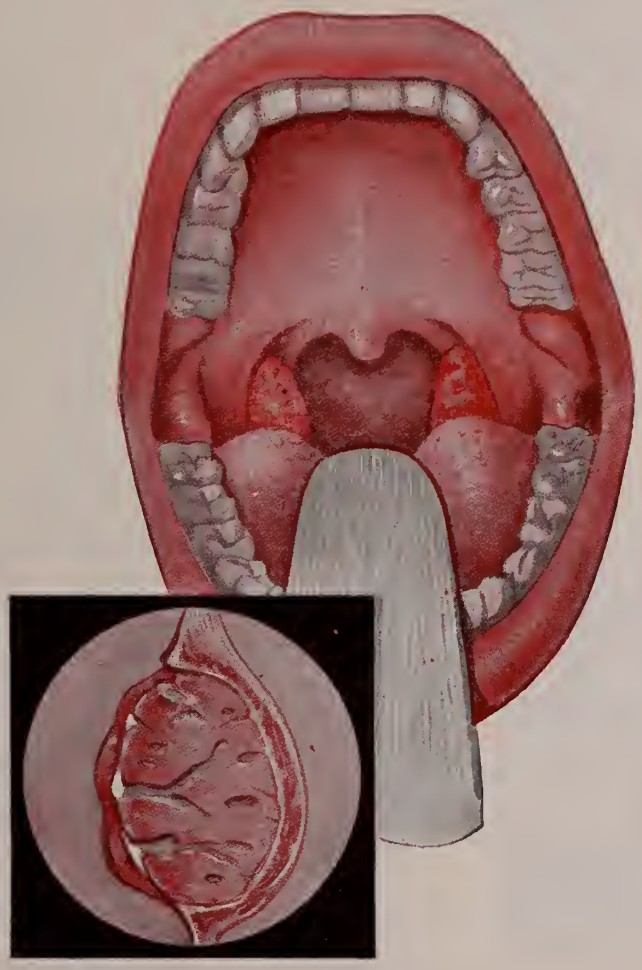
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Sayer, R. J.; Michel, J.; Moll, F. C., and Kirby, W. M. M.: Am. J. M. Sc. 221:256 (March) 1951

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rida Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '52
rida Medical Districts	William C. Roberts, Panama City	Council Chairman	
A-Northwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Pensacola, Oct. 22, '51
B-Northeast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Orlando, Oct. 26, '51
C-Southwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	B'denton-Sarasota, Oct 24, '51
D-Southeast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Vero Beach, Oct. 25, '51
rida Specialty Societies			
ademy of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	Hollywood, Apr. 27, '52
rgy Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	" "
sthesiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
ipter, Am. Coll. Chest Phys.	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
rm. and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
alth Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
art Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	" "
ustrial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	" "
rology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
and Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
nthal & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	" "
hopedic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	" "
hological Society	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Laudardale	" "
iatric Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	Orlando, Nov. 10-11, '51
ctologic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	Hollywood, Apr. 27, '52
diological Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
logical Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
rida—			
asic Science Exam. Board	Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 10, '51
lood Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
lue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando, Dec. 2, '51
lue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 27, '52
ental Society, State	John I. Todd, D.D.S., Jacksonville	Tom Price, D.D.S., Miami	Jacksonville, Apr. 20-23, '52
ospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando, Dec. 3-4, '51
edical Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	Jacksonville, Nov. 25-27, '51
edical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
urses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Oct., 1951
harmaceutical Association, State	Mr. Euless Watford, Chipley	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-21, '52
ublic Health Association	Mr. David B. Lee, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, October, 1951
uberculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Pt. St. Joe	
oman's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	Hollywood, Apr. 27-29, '52
erican Medical Association	John W. Cline, San Francisco	Geo. F. Lull, Chicago	
.M.A. Clinical Session	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Los Angeles, Dec. 4-7, '51
thern Medical Association	Curtice Rosser, Dallas, Texas	Mr. C. P. Loranz, Birmingham	Dallas, Texas, Nov. 5-8, '51
bama Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19, '52
rgia, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 11-14, '52
E. Hospital Conference	Edwin B. Peel, Atlanta	Mr. R. G. Ramsey, Jr., Memphis	Atlanta, Apr. 16-18, '52
theastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath, B, MacInnis, Columbia, S.C.	Augusta, Ga., Mar. 21-22, '52
theastern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	Boca Raton, Apr. 2-5, '52
theastern Surgical Congress	Joseph S. Stewart, Miami	B. T. Beasley, Atlanta	Atlanta, Mar. 10-13, '52
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	Escambia *Santa Rosa*	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	75	68	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	7	100%	
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	Walton-Okaloosa	Arthur G. Williams, Jr., M.D. Valparaiso	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker-Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	14	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	John T. Benbow, M.D. Chattahoochee	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	Quarterly 7:30 P.M.	57	56	
	Suwannee	John N. Sims, Sr., M.D. Suwannee St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	7	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		3	100%	
	Taylor *Dixie-Lafayette*	Ralph J. Greene, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	229
B	Alachua *Bradford, Gilchrist, Union*	James M. McClamroch, M.D. 903 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 819 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	46	100%	
	Duval *Clay*	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	242	234	
	Marion *Levy*	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	27	100%	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
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C	Hillsborough	R. Renfro Duke, M.D. 708 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	163	159	
	Manatee	Roderic O. Jones, M.D. 430 10th St., W. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	2nd Tuesday 8:30 P.M.	21	19	
	Pasco-Hernando-Citrus	Gail M. Osterhout, M.D. Box 296 Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	13	100%	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	Claude B. Wright, M.D. 214 First Fed. Bldg. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	184	182	
	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 203 Van Skike Bldg. Sarasota	2nd Tuesday 8:30 P.M.	42	41	
	DeSoto-Hardee-Highlands-Glades	Hubert W. Coleman, M.D. Box 98 Avon Park	Stanley K. Wallace, M.D. Sebring	2nd Tuesday 8:00 P.M.	26	24	
	Lee-Charlotte-Collier-Hendry	William H. Grace, M.D. 1925 McGregor Blvd. Ft. Myers	Angus D. Grace, M.D. 308 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	24	100%	C-6-52 Leldon W. Martin, M.D. Sebring
	Polk	John W. Vaughn, M.D. Box 475 Lakeland	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	86	83	559
D	Indian River	Erasmus B. Hardee, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	
	Palm Beach	R. M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	Lorenzo James, M.D. 1300 N. Dixie Ave. West Palm Beach	3rd Monday 8:00 P.M.	103	97	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	St. Lucie-Okeechobee-Martin	Julian D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	16	14	
	Broward	M. Austin Loveioy, M.D. 409 Blount Bldg. Ft. Lauderdale	Thomas L. Roberts, Jr., M.D. 408 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	80	78	
	Dade	Jack Q. Cleveland, M.D. 167 Alcazar Ave. Coral Gables	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	582	537	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	Ralph Herz, M.D. 420 Simonton St. Key West	Herman K. Moore, M.D. 600 Elizaheth St. Key West	2nd Thursday 8:00 P.M.	10	100%	798

THE DIATHERMY SITUATION

The many users of old type diathermy equipment have asked for clarification of F.C.C. Regulations as pertaining to diathermy. The June 2 issue of the Journal of the American Medical Association contains an article on Page 481 which explains the situation very simply and completely. Here are some of the questions which this article answers:

1. When were the F.C.C. diathermy regulations enacted?
   June of 1947.

2. What is the final date for use of unapproved diathermy equipment?
   June 30, 1952, "According to the law."

3. Is approved equipment readily available?
   "The Council of Physical Medicine and Rehabilitation has on its accepted list diathermy equipment which not only meets the requirements of the Council, but also carries the 'type approval' of the Federal Communications Commission. Although almost a year remains before the law goes into effect, the shortages of materials at the present time make it difficult for the manufacturers to provide diathermy equipment to meet the demand. The placing of orders immediately would seem advisable."

4. Can old short wave diathermy equipment be converted to meet F.C.C. Regulations?
   "Uncontrolled short wave diathermy apparatus cannot be changed economically to meet the rules and regulations of the Federal Communications Commission."

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Maurice M. Greenfield and Christian Keedy

Malignant Disease During Pregnancy
Henry L. Harrell

Refrigerated Homogenous Bone
Wendell J. Newcomb

Urinary Frequency in Women
Joseph C. Hayward, Louis M. Orr, II and James B. Glanton

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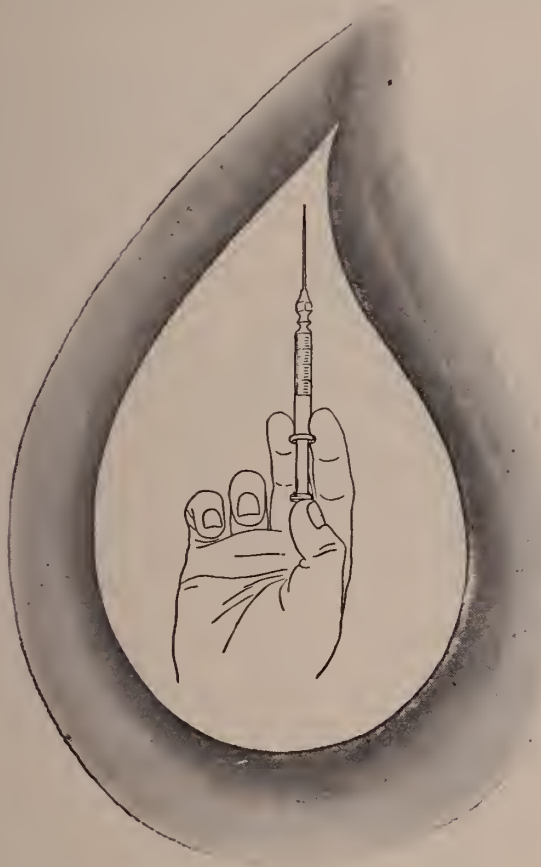
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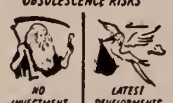


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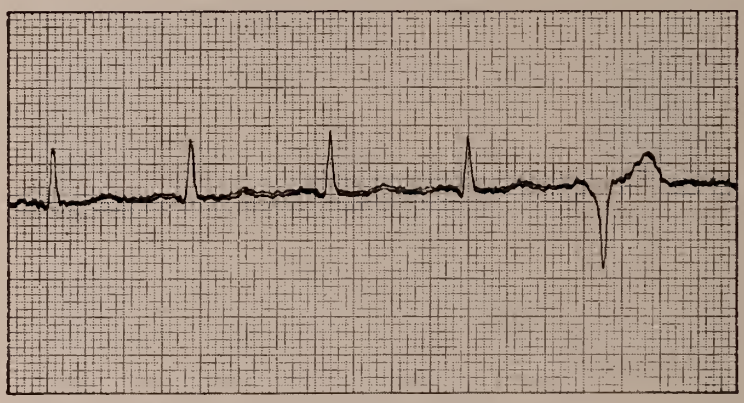
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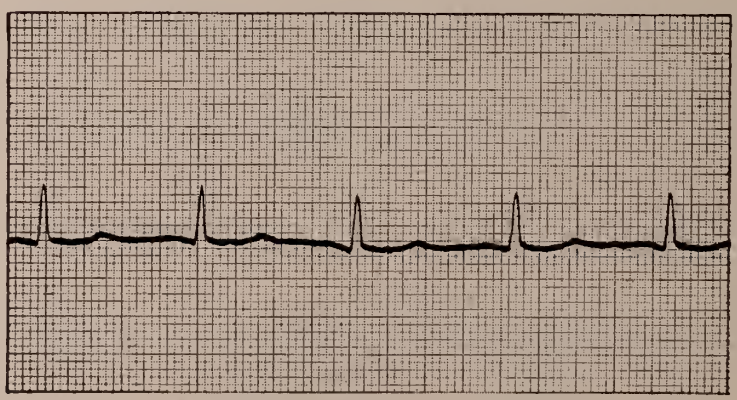
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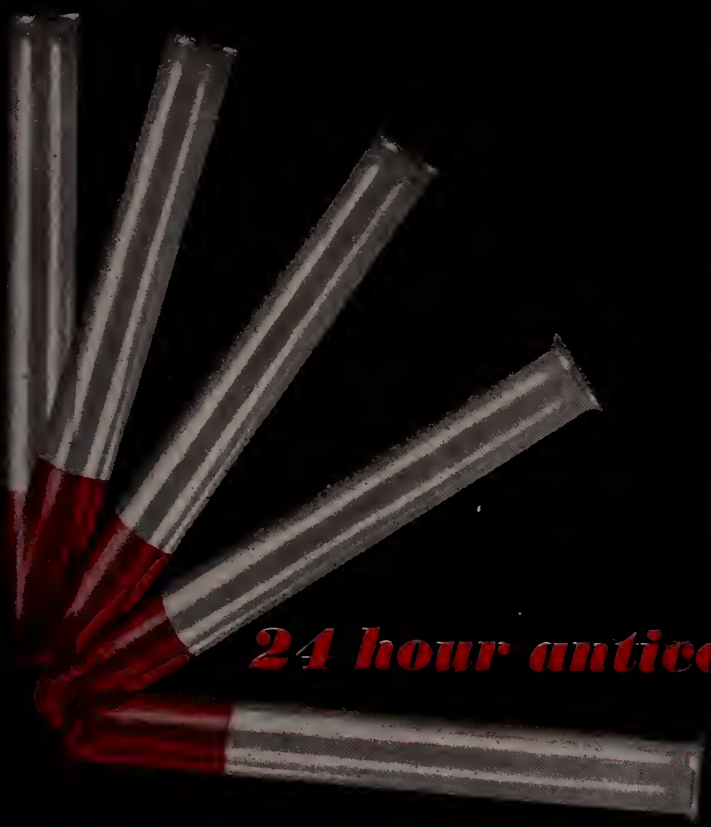
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1. *Smiles, William J.: Lang-Acting Heparin Preparatian: A Useful Adjunct in Anticoagulant Therapy. U. S. Armed Farces Med. J., Val. II., No. 1 (Jan.) 1951.*

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2. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293-299, Sept., 1949.

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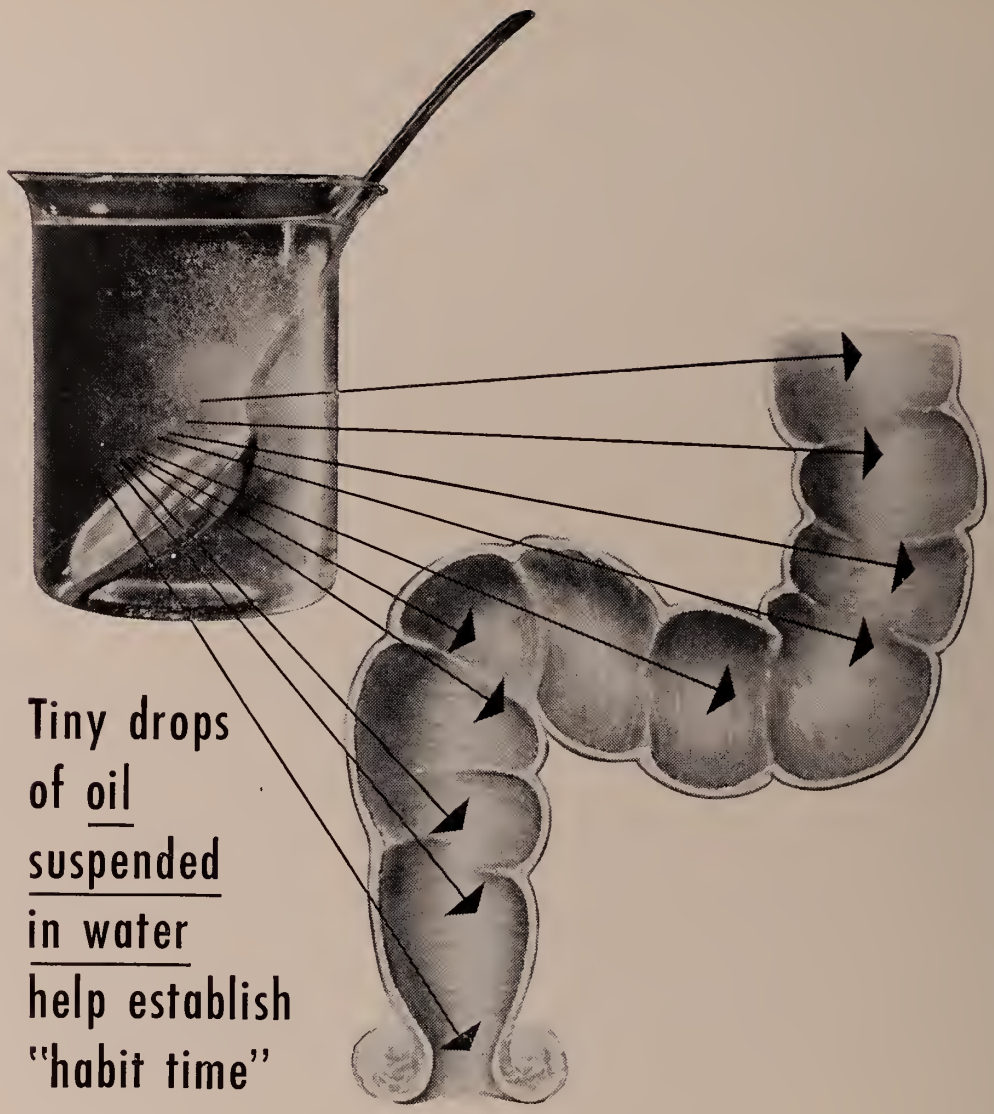
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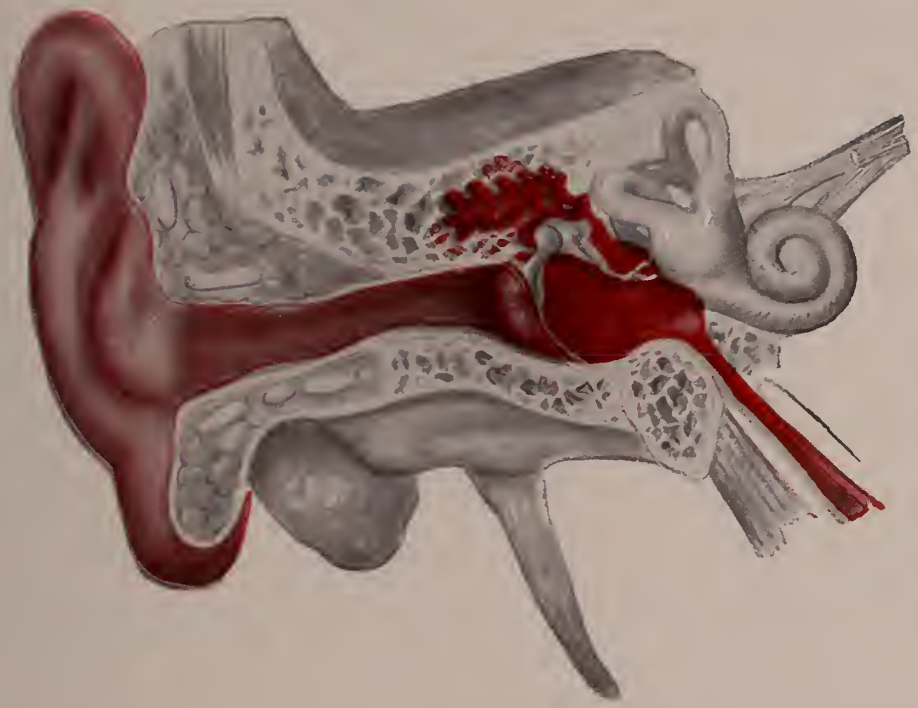
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY
Volume XXXVIII Jacksonville, Florida, November, 1951 No. 5

Cerebral Arteriography: Its Use in Localization and Diagnosis of Intracranial Lesions

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AND
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MIAMI

Roentgen examination of the skull during perfusion of the intracranial vessels with a radiopaque material was first introduced by Egas Moniz[1] of Portugal in 1927. The technic was readily accepted in Europe, but its value was not immediately recognized in this country. Few neurosurgeons in America used the technic until after Dandy[2] published his monograph on the treatment of intracranial aneurysms in 1944. It immediately became apparent to those interested in this work that cerebral arteriography had much to offer in the localization and diagnosis of intracranial aneurysms, arterial thromboses, and other intracranial vascular anomalies.

The cerebral arteries, being relatively constant in their position, became valuable anatomic landmarks, and distortion or displacement of these vessels could be used to localize space-occupying lesions. Further experience showed that in certain tumors there frequently developed a characteristic vascular pattern or "stain," making it possible not only to localize the lesion but also to determine its histologic nature prior to surgery. Among the tumors which are frequently identified by their vascular stain are glioblastomas and meningiomas.

It should be noted that cerebral arteriograms have not replaced intracranial air studies. The two procedures supplement each other, and frequently both must be done before an intracranial lesion can be satisfactorily localized. Air studies have the advantage of filling all of the fluid spaces at one time. Usually, to obtain a complete cerebral arteriogram, it is necessary to perfuse successively both carotid arteries and one vertebral artery with some radiopaque substance. Clinical signs localizing the lesion to the right or left cerebral hemisphere or to the posterior fossa make it necessary to inject only one artery. The usual procedure is to inject either the right or left common carotid artery, which fills the anterior two thirds of the intracranial vessels on the injected side.

Several contrast mediums have been used in this work during recent years. One of the earliest agents was thorotrast, which has now been largely rejected because of its irritation to soft tissues with late fibrosis and its possible deleterious radioactive effects. In this country 35 per cent diodrast, familiar to most of the profession through excretion urography, is used. All of our studies are performed with this contrast material and have been satisfactory. We have had no serious reactions to this drug.

In obtaining a carotid arteriogram a 17 or 18 gage needle is inserted into the common carotid artery either by cutting down on the artery or by inserting the needle into the artery through the skin. We prefer the open operative method for in our hands studies of better diagnostic quality are obtained. There are several reasons for better arteriograms when the vessel is surgically exposed: First, the position of the head may be changed without fear of dislodging the needle and getting infiltration of soft tissue. Second, the external carotid artery can be compressed, permitting good visualization of the internal carotid artery and its branches and avoiding the confusing outlines of

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 23, 1951.

the external carotid artery. Third, the Bucky diaphragm on the ordinary x-ray table may be used for both the anteroposterior and lateral films, thus obtaining good detailed arteriograms. Teamwork and cooperation between the neurosurgeon and radiologist as well as the technicians are essential in order to carry out the precise timing required to obtain diagnostic arteriograms with simple roentgen equipment used in all hospital x-ray departments. No special radiographic equipment is necessary, although in some larger centers special serialographic devices are available.

All of the arteriograms we will show were made by the following open operation technic. Preoperatively, the common carotid artery is compressed for at least twenty minutes to be sure the patient can tolerate loss of that blood supply should we wish to ligate the common or the internal carotid artery after the arteriogram is made. The patient is subjected to general endotracheal anesthesia on the stretcher. The common carotid artery is exposed, and the dissection is carried up above its bifurcation into the internal and external carotid arteries. A small amount of procaine is injected beneath the adventitia at the bifurcation to prevent reflexes of the carotid sinus. One rubber dam drain is placed around the common carotid and another around the external carotid artery. The patient is then taken to the x-ray department and moved onto the x-ray table. A 2 inch 17 gage needle bent at a 45 degree angle and equipped with a 3 way stopcock is inserted into the common carotid artery. With the external carotid artery constricted by twisting the rubber dam drain, 10 to 15 cc. of 35 per cent diodrast is injected as rapidly as possible. A one and one-half second exposure is started just after the beginning of the injection. The injection is usually complete slightly before or simultaneous with the end of the exposure. After each injection of diodrast the artery is perfused with 20 to 30 cc. of a 2½ per cent solution of sodium citrate. Two injections are made with the head in the lateral position and two with it in the anteroposterior position. In taking the arteriograms in the anteroposterior position the tube is angled towards the feet about 20 to 25 degrees to throw the orbit and the sphenoidal ridge below the level of the bifurcation of the internal carotid artery. By manually compressing the common carotid artery on the opposite side while the injection was being made, we have sometimes been successful in filling the anterior and middle cerebral arteries bilaterally.

Report of Cases

Case 1. — A 17 year old white girl had had bilateral mastoiditis followed by encephalitis at the age of 4 years. Petit mal and grand mal seizures followed this illness and recurred frequently until the age of 15 when the petit mal seizures ceased, but the grand mal seizures continued to recur at about monthly intervals. Sudden onset of severe headache occurred, followed in about one hour with loss of consciousness and repeated convulsive seizures. Examination revealed semicoma, stiffness of the neck of considerable degree and bilateral Babinski sign. Lumbar puncture revealed the fluid to be grossly bloody with an initial pressure of 600 mm. of water. The patient's mental state gradually cleared, and as it did, she complained bitterly of headache on the right. An arteriogram of the right carotid artery obtained on Nov. 28, 1950 showed a double aneurysm of the right internal carotid artery and a vascular angioma in the left parietal region (figs. 1 and 2). Ligation of the right common carotid artery was performed.

Case 2. — A 26 year old white woman gave a history of an automobile accident approximately one year before admission. At the time of the accident she was unconscious for two weeks. On regaining consciousness she became aware of definite pulsation in the left orbit associated with loud head noise. She also complained of double vision. Examination revealed pulsating proptosis of the left eye, engorgement of the vessels in the retina and conjunctiva on the left. Loud bruit could be heard over the left frontal region. An arteriogram of the left carotid artery on March 28, 1949 showed an arteriovenous



Fig. 1. — Bilateral cerebral arteriogram showing left-sided angioma being fed by both the left anterior and middle cerebral arteries. The right carotid artery was needled, and the left compressed to obtain filling on both sides.

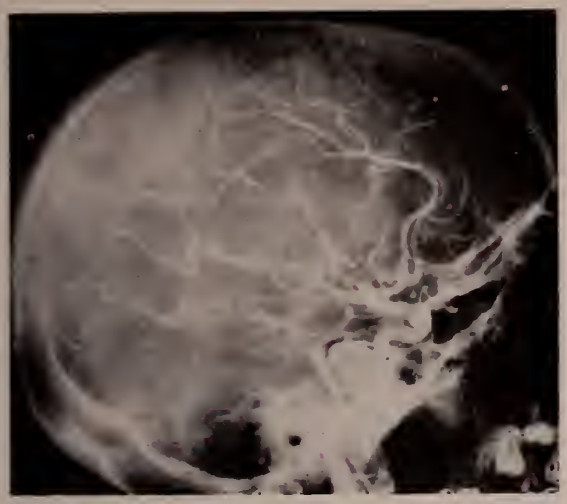


Fig. 2. — Lateral projection showing two small aneurysms of the right internal carotid artery at and above the level of the clinoid processes. The angioma in the frontoparietal region is also seen.

fistula between the left internal carotid artery and the cavernous sinus (fig. 3). The internal and external carotid arteries on the left were ligated. Following this procedure the bruit ceased, but the exophthalmos remained unchanged. Left frontal craniotomy was performed, and the left internal carotid artery was clipped intracranially.

Case 3. — A 40 year old white woman had had right hemiparesis for seventeen years, and spontaneous subarachnoid hemorrhage had occurred three years prior to hospitalization. Sudden onset of severe headache and pain down the spine were experienced forty-eight hours before admission. Examination revealed moderate stiffness of the neck, right hemiplegia, deviation of the tongue to the right or protrusion, a positive Babinski sign on the right, and great spasticity of the right arm and leg. The spinal fluid was grossly bloody. Bruit could be heard over the left temporal region. Compression of the left common carotid artery diminished the bruit by approximately 80 per cent. An arteriogram of the left common carotid artery obtained on May 26, 1950 showed an arteriovenous malformation in the left parietal region (fig. 4).

Case 4. — A 55 year old white man had experienced fainting spells initiated by a sensation of a "strange odor" for one week, and nausea but no vomiting, and mild headache for several weeks. Examination revealed questionable facial weakness and questionable increased tendon reflexes on the right. Spinal fluid studies gave normal results except for 196,000 red blood cells. An arteriogram of the left carotid artery showed displacement of the branches of the middle cerebral arteries upward (fig. 5). Gradual increase of aphasia and loss of memory followed. The patient was later operated on for a tumor of the left temporal lobe.

Comment

Cerebral arteriography is not without some risk. With inadequate sedation convulsive seizures may occur at the time of injection of the diodrast. The pupil on the side of the injection usually dilates and remains dilated for several hours. Transient contralateral hemiplegias occur in about 4 per cent of the cases and permanent hemiplegias in approximately 1 per cent.[3] Sensitivity reaction to iodine occasionally occurs. We have had no serious complications in our first 50 cases now completed.

The procedure has definite value, but, because of the risk involved, should not be used indiscriminately. It is indicated in all patients with spontaneous subarachnoid hemorrhage in the absence of hypertensive cardiovascular disease and arteriosclerosis. It is indicated in patients with severe recurrent unilateral headache of a throbbing character which may be relieved by compression of the carotid artery on the affected side. It is indicated in patients with lateralizing neurologic signs in whom an air study has not revealed the lesion. It is indicated in all patients who have lateralized neurologic signs with or without increased intracranial pressure before an air study is made. In the presence of increased intracranial pressure a cerebral arteriogram may be made without fear of upsetting the intracranial balance and forcing immediate operation. In this respect it has a great advantage over air studies.

This procedure is not indicated in patients with vague neurologic complaints without definite neurologic signs. It should not be used as a diagnostic screening procedure for all patients with headache. We believe it is contraindicated in patients with hypertensive cardiovascular disease, in patients with advanced generalized arteriosclerosis, and in patients sensitive to iodine.



Fig. 3. — Arteriovenous fistula showing filling of the cerebral veins, cavernous sinus, and internal carotid artery.

Summary

The value of cerebral arteriograms in the localization and diagnosis of intracranial lesions is discussed, and the roentgen and surgical technic is described. The risks of this diagnostic method are reviewed, and the indications and contraindications for its use are presented.

Four illustrative cases are reported.

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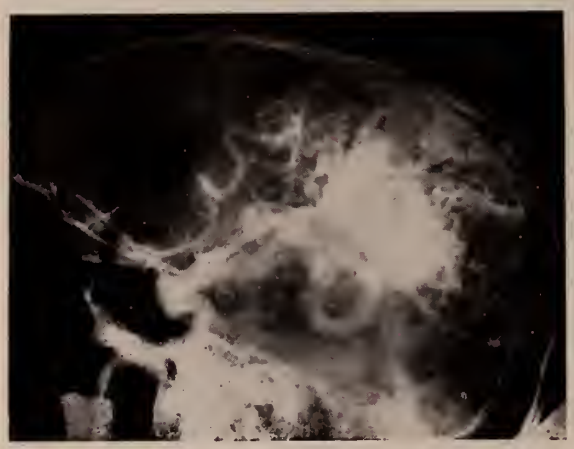


Fig. 4. — Large congenital angioma in the left parietal zone being fed by the middle cerebral artery.

Discussion

DR. ROBERT W. CURRY, Orlando: I have enjoyed this paper not only because it is an excellent presentation but also because the subject is a timely one. Cerebral angiography is still in its infancy, and its possibilities have only begun to be explored, but there seems little doubt that any other radiologic procedure gives so much information in the field of neuroradiology with so little discomfort and so little danger to the patient. Cerebral angiography not only localizes the site of the cerebral tumor, but also indicates its probable pathologic structure. No other radiologic procedure can do this. I believe that in time cerebral angiography will supplant intracranial air studies in patients having lateral localizing signs, and often it is the only informative procedure in patients having vascular lesions such as aneurysms and hemangiomas. For the demonstration of supratentorial tumors which are not in the midline and are not in the posterior portion of the occipital lobes, cerebral angiography is as accurate in diagnosis as intracranial air studies. Both procedures will sometimes be necessary in brain tumor suspects since either procedure may give a false negative result, and the accuracy of diagnosis will be improved by making free use of both procedures.

Cerebral angiography can be carried out satisfactorily by either the open operative method or the percutaneous method. In the percutaneous method the needle is punctured through the skin directly into the common or internal carotid artery and the proceduce is similar to the ordinary venipuncture. It has the advantages that no operation is required, the patient need not be hospitalized, and hematomas in the soft tissue of the neck are perhaps not as common as with the open operative method. It can be carried out under either local or general anesthesia, and when the procedure is over, the patient has no symptoms except a slight soreness in the neck. Extravasation of diodrast into the carotid sheath is not a serious complication and requires no treatment.

The patient's head cannot be rotated when this method is used, but no disadvantage results since equipment to hold cassettes for taking both anteroposterior and lateral views of the skull can be easily and inexpensively made. The following lantern slides show such equipment. This rather crude but simple apparatus has given satisfactory results. (First lantern slide.) This is a lantern slide to show such an apparatus with the patient's head in position. You see here that the surgeon has a syringe filled with diodrast ready to make the injection. This apparatus holds three cassettes so that it is possible to make three x-ray exposures after each injection and thus show filling of the arteries, the capillaries and the veins, in turn. Stereoscopic anteroposterior and lateral views are made by changing the position of the x-ray tube and repeating the procedure.

(Second lantern slide.) This is a lantern slide of the same apparatus without the patient's head in place. Each cassette is held in a lead-back steel tray and, after the exposure, is pulled out of the way by a string. I show these slides so that you will realize it is possible to obtain satisfactory roentgenograms with simple and inexpensive equipment.

A surgeon who is experienced with percutaneous puncture of the carotid artery may expect to be successful in about 90 to 95 per cent of his cases. The method requires skill, and the first few attempts are often unsuccessful. Initial failure should not discourage anyone who would like to use the method. It is used routinely at the Johns Hopkins Hospital, and it is an unusual case there in which the open operative method must be resorted to. Thank you.

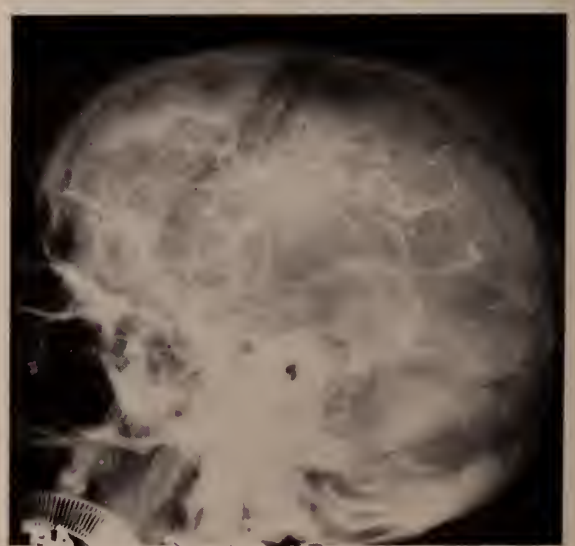


Fig. 5. — Displacement upward of the middle cerebral or sylvian group of vessels by a tumor of the temporal lobe.

Dr. Christian Keedy, concluding: I want to thank Dr. Curry very much for discussing this paper. One point I desire to emphasize in closing is that this procedure is not wholly without risk. There have been reports in the literature of complications as high as 10 per cent reported by Scoville and Whitcomb in Hartford. In 104 cases they reported 4 deaths, 3 cases of permanent hemiplegia, 2 cases of temporary hemiplegia, 1 case of thrombosis of the internal carotid artery and 2 cases of convulsive seizures. Other authors reported the incidence of transitory hemiplegia following the injection of diodrast into the carotid artery as 4 per cent, with an incidence of about 1 per cent of permanent hemiplegia following this procedure. We have been fortunate in not having had any serious complications, but I fear we are probably due to have some.

We have no argument with those who prefer the percutaneous technic. In our hands we get better diagnostic films using the open technic with fewer complications. With the percutaneous technic there is always a chance — and there have been several cases reported — of having serious hemorrhage into the neck. In 1 case death was reported after a percutaneous arteriogram had been obtained. Thank you.

Treatment of Urinary Frequency in Women

Joseph C. Hayward, M.D.
Louis M. Orr, II, M.D.
and
James B. Glanton, M.D.
Orlando

One of the commonest, and oftentimes most distressing, complaints referable to the urinary tract in women is frequency of urination. Ordinarily this symptom is dismissed without too much thought after a cursory urinalysis and a prescription for some type of sedative for the bladder. In many instances, however, the recurrence or continuation of the complaint makes further consideration and investigation necessary.

All of us are cognizant of the gross anatomy of the female urethra and realize that its proximity to the vagina exposes it to the trauma of coitus and childbirth, as well as to frequent infections. It is to be recalled that there are numerous glands along the course of the urethra lined with transitional or pseudocolumnar epithelium. Skene's glands are near the meatus, and the glandular elements in the posterior portion have been microscopically proved to resemble the glands seen in the prostate of newly born male infants. They have been considered by some as homologues of the male prostate. It is primarily the glandular structures present in the posterior urethra which are involved in the chronic infections.

Numerous pathologic entities may be responsible for frequency, and the commonest ones should be briefly reviewed in order that the possible etiologic factors may be properly evaluated in the management of urinary frequency.

The most frequently observed pathologic condition is either an acute or chronic granular urethritis, which is observed in many women who present no other urologic abnormality. The source of this infection may be trauma at the time of childbirth, coitus or a specific infection. Edema and irritation about the neck of the bladder are also a frequent cause of this annoying symptom. Usually there is associated involvement of the trigone. Calculi and urethral diverticulum, or a simple diverticulum without calculous formation, may also cause frequency. Infections involving the cervix and vagina are sources for the chronic urethritis so often present. It is most important that the examination eliminate these structures as possible etiologic factors.

Urethral caruncles may be most annoying and many times produce a rather severe degree of frequency. Only too often caruncles are inadequately treated by repeated local applications of various caustics without actually destroying the complete lesion. Tumors of the bladder, although usually first detected because of gross hematuria, are occasionally first evidenced by frequency. Interstitial cystitis (Hunner's ulcer) classically produces great frequency and is acutely distressing to the patient.

One of the grossest errors made in the management of recurrent frequency is the failure to investigate the mid and upper portions of the urinary tract. Chronic pyelonephritis has often proved to be the focus of infection and is easily overlooked unless complete cystoscopic studies are carried out. Some persons persistently experience frequency without any evident gross pathologic condition in the urinary tract and, in our experience, many of

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 23, 1951.

these patients present changes indicating that an allergic reaction, in all probability, is the causative factor. In many instances therapy directed toward correction of the allergy has given the patients complete relief.

The pathologic changes most commonly responsible for frequency must be kept in mind if the difficulty is to be properly approached. Chronic granular urethritis with cicatricial formation is the greatest offender. Several of the other lesions may be secondary to the urethritis, namely, trigonitis, polyps, fibrosis of the urethral wall and urethral stricture, chronic low grade cystitis and, in some instances, acute hemorrhagic cystitis.

A history of trauma incident to childbirth or infection following repeated catheterizations usually is elicited from patients experiencing recurrent frequency. Urinalysis may often result in normal findings, although usually a few white blood cells and/or red blood cells are present. Cystoscopy or panendoscopy ordinarily demonstrates the pathologic condition which is producing the specific symptoms. In the event that investigation of the lower and mid portions of the urinary tract gives normal results, a complete study of the upper portion of the tract is imperative.

Management

The management of urinary frequency in women in the presence of acute infection ordinarily presents little difficulty with the antibiotics now available. The most encouraging results have been reported with aureomycin, chloromycetin and terramycin. It is well to keep in mind, however, that some of these preparations have side effects which may be more distressing than the patient's original complaint. Detailed inquiry regarding possible history of ulcer or other gastrointestinal difficulty, particularly when one is anticipating the use of aureomycin, may save considerable anxiety and unnecessary complications. Within the last year we had a patient who, on questioning, failed to give us a history of duodenal ulcer, and during the course of his convalescence aureomycin was given orally. His progress was entirely satisfactory until the day before his anticipated dismissal, at which time a severe hemorrhage occurred, which was uncontrollable, and the patient expired. An autopsy was obtained and revealed a large ulcer crater with an eroded artery in its center which had produced the fatal hemorrhage.

Since the advent of the newer preparations, some are prone to overlook the commoner less expensive sulfonamides which, many times, will prove just as effective as the more expensive antibiotics. Penicillin as a routine medication in chronic infection of the urinary tract has not proved as satisfactory as many other forms of therapy. Ordinarily, in infections of the urinary tract, heavy dosages are not necessary. In a control series several years ago at Duke University there was no appreciable difference in the results obtained following high concentration of sulfonamides and those from minimum dosage.

In examination of the urine of a patient with frequency, the hydrogen ion concentration may be an important causative factor, particularly here in Florida, as many winter visitors enjoy their annual citrus juice allotment in a concentrated two or three week interval. Oftentimes this excessive intake results in highly alkalinized urine which may be the sole factor responsible for frequency with attendent dysuria.

As most of the patients experiencing chronic frequency have a cicatricial granular urethritis, treatment ordinarily must be directed toward the urethra. Urethral dilatations at weekly intervals, until a 34 French sound can be introduced, combined with irrigations of the bladder and endoscopic treatments, have proved efficacious in most instances.

There are some who advocate fulguration of the urethra and vesical outlet under anesthesia, and this method has met with considerable success as reported by Spence and others. Gentleness must be exercised in urethral dilatations, or the patient will experience aggravation of symptoms rather than improvement. Office management of the majority of these patients is easily carried out, and topical anesthesia, using metycaine solution in the bladder with cocaine jelly applied to the urethra, is well tolerated and eliminates much of the discomfort of the treatment.

There are some cases in which chronic infection about the neck of the bladder has produced a contracture at the urethrovesical junction from scar tissue and hypertrophy of the posterior vesical lip, which can only be satisfactorily managed by transurethral resection of the vesical outlet. This procedure, when judiciously used, has met with much success. Great care must be exercised to avoid injury to the sphincter muscle at the time of surgery which might prove far more serious than the recurrent frequency for

which the patient was originally receiving treatment.

Recently it has been observed that numerous patients who have failed to be relieved by the usual form of therapy have been greatly benefited by dealing with the problem on the basis of an allergic manifestation. Several antihistaminic drugs have been used, but pyribenzamine, 50 mg. four times daily and in some instances, 25 mg. four times daily, has proved the most valuable agent in dealing with this form of allergy. What the future possibility of this approach holds remains to be seen, but it should be stressed that before instigating such therapy other gross pathologic changes throughout the entire urinary tract must be ruled out if reasonable success is to be expected.

The prognosis in women suffering from urinary frequency is generally good, although a proneness to recurrence is common. Often by the time these patients are thoroughly evaluated, the basic pathologic process has been gradually progressive over a period of years, which progression makes eradication of the difficulty more trying.

Frequency of urination in women, regardless of age, which persists after simple therapeutic measures have been used, should be considered as a symptom of great importance and makes necessary a complete investigation in order not only to plan proper therapy but to avoid serious consequences to the patient.

Summary

Frequency of urination in women is a common complaint and merits investigation as to etiology, particularly when recurrent. The anatomy of the urethra and its glandular structures explains the high incidence and chronicity of this difficulty.

A complete study of the urinary tract is necessary in the management of chronic frequency and often reveals the specific cause of the patient's discomfort.

Proper treatment can be instituted only when the cause of the trouble is known, and therapy is then directed toward its correction. A number of persons experience frequency due to an allergic reaction, and in many instances the response to the antihistaminic preparations is rather dramatic.

Persistence of urinary frequency after simple therapeutic measures have failed indicates the need for a thorough study of the urinary tract including roentgen examination. Much subsequent difficulty can be prevented by early proper management of this common symptom.

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Discussion

Dr. Erasmus B. Hardee, Vero Beach: I am sure we have all enjoyed this timely paper on urinary frequency in women. This is a condition with which every general practitioner is confronted, and unfortunately, most of us are unable to make satisfactory cystourethroscopic examinations. Nor is it economically practical or possible to refer all of the patients with this complaint for urologic studies. We all, however, are equipped to make careful and diligent physical examinations and urinalyses. And in a large percentage of these cases the frequency can be corrected by simple office procedures. I have found in a good many instances in which the usual urinary sedatives fail to give relief that dilatation of the urethra with sounds and irrigations and distention of the bladder with a 1:8,000 solution of potassium permanganate often give soothing relief.

In the older group of women urinary frequency and tenesmus are often associated with senile vaginitis. In these patients the use of estrogenic hormones often gives dramatic relief.

Dr. Hayward has directed attention to the satisfactory results obtained in a large percentage of cases of urinary frequency with antiobiotics and sulfonamides. And may I re-emphasize the economic importance in the use of sulfonamides in the treatment of these cases? I believe there is a tendency among most of us to try first the newer and most expensive antibiotics. There is, however, one condition in which the drug of choice appears to be an antibiotic in preference to the cheaper sulfonamides. This is abacterial pyuria. Fortunately, this condition is not frequently encountered and can often be recognized by its sudden onset with frequency and burning so severe that at times they precipitate incontinence. Usually, within twenty-four hours the patient is symptom-free. Pyuria, however, may persist for several days before the urine is pus-free, that is, with the use of the antibiotics. It is logical, therefore, to assume that this is a virus infection since no organisms have been isolated.

Dr. Hayward, concluding: I wish to thank Dr. Hardee for his kind remarks. I think one point that we should all call to mind is that we think of this symptom particularly in order persons and perhaps sometimes overlook the fact that urethritis actually occurs in female children and infants. It is almost dramatic the way they are relieved many times by a few simple urethral dilatations. I would suggest, if you attempt dilatations in young females, that you not try too much without some type of anesthesia because ordinarily they are not too cooperative. Thank you.

A. M. A. Clinical Session

December 4-7, 1951

Los Angeles

Malignant Disease During Pregnancy

HENRY L. HARRELL, M.D.
OCALA

Because I had 2 cases of malignant tumor of the breast during pregnancy this last year, I have taken the opportunity to study the recent literature on the subject. The main emphasis is placed on: (1) the effects of the malignant disease on the pregnancy, (2) possible change in prognosis for the malignant condition because of the pregnant state, and (3) the effects of treatment, particularly irradiation, on the course and outcome of the pregnancy.

The 2 cases are reported as follows:

Report of Cases

Case 1. — A white woman, gravida IV, para II, aged 34, was first seen on Oct. 19, 1949, at which time she was six weeks pregnant. On Jan. 16, 1950, a nodule was discovered at the outer upper margin of the left breast. This was removed and found to be malignant lymph tissue. It and several nodes removed from the axilla showed numerous Dorothy Reed cells and numerous mitoses, which were interpreted as evidence of Hodgkin's disease of the Hodgkin's sarcoma type. The patient had more than the usual anorexia during the first two trimesters, but had similar trouble during her other pregnancies. The blood picture on January 24 was white blood cells, 6,200; red blood cells, 3,560,000; and hemoglobin estimation, 11.6 Gm. The roentgenologist gave the following report on her therapy:

"The patient was referred on March 3, 1950 for radiation therapy with biopsy-proved diagnosis of Hodgkin's disease. Roentgen therapy was instituted on that date with the use of the following technic: A single left axillary port, 10 x 10 cm., 50 cm. skin target distance; 200 kv. with ½ mm. Cu. and 1 mm. al. filter. Treatment every second day from March 3; total 1,467 r units, air dose.

"The patient responded well to treatment."

Supportive iron therapy was also given. She began gaining weight in the seventh month of pregnancy, but remained weak and was in bed much of the time. Vomiting continued. During the last three weeks she had numerous and frequent irregular inconsequential uterine contractions and went into labor on June 9. After thirty-six hours of rather exhaustive labor with development of uterine inertia, she was delivered of a normal female infant by cesarean section, having the fallopian tubes transected and tied at the same time. The postpartum course was uneventful. The baby has shown no signs of Hodgkin's disease to the present time.

A small nodule was felt in the mother's left axilla on August 25. This remained stationary in size until January 1951, when it was thought to be enlarging and the patient began to complain of increasing anorexia. It was not a definite recurrence, but she was given roentgen therapy again for safety and, following radiation over a period of seventeen days, the node was still palpable, but was smaller in size.

The second course of radiation therapy given in January 1951 was as follows: 580 r units air dose, left lateral axilla; 860 r air dose, left anterior axilla; and 860 r air dose, left posterior axilla, given in a period of seventeen days.

Case 2. — A Negro woman, gravida IV, para III, was seen on Sept. 22, 1949, the fifth day after the delivery of her third child by a midwife. At that time, she had numerous large nodules in both breasts, the larger 2 to 3 cm. in diameter. There were no palpable axillary nodes. She was breast-feeding her baby. The child was placed on a formula, and on November 1 both breasts were removed by simple mastectomy. Pathologic diagnosis was as follows: Right breast, adenocarcinoma, grade II. Left breast, adenocarcinoma, grade I. The roentgenologist gave the following report on her therapy:

"The patient was referred for treatment on Nov. 28, 1949 with biospy-proved diagnosis of adenocarcinoma of the breast, bilateral, postoperative. Roentgen therapy was instituted on that date and completed on Jan. 12, 1950. The treatment technic was as follows: Right and left supraclavicular portals, 7 x 9 cm., 250 kv. radiation, Thoraeus No. 2 filter, 50 cm. skin target distance. Total each port, 2,580 r units, skin dose.

"Right and left lower anterior portion of the chest, ports 9 x 15 cm., distance 50 cm., 140 kv., no filter. Total 1,856 r units, air dose.

"Right and left upper anterior portion of the chest, including the anterior axillas, ports 9 x 15 cm., distance 50 cm., 200 and 250 kv., ½ mm. Cu. and Thoraeus No. 2 filter. Total 2,196 r units, skin dose.

"Right and left posterior axillary region, ports 10 x 10 cm., 50 cm. distance, 250 kv., Thoraeus No. 2 filter. Total 2,064 r units, skin dose."

Two portals, right and left, were treated at approximately daily intervals, and the patient withstood therapy well, except for moderate intermittant nausea. She was pregnant on beginning the radiation therapy and delivered a normal baby approximately seven months after completion of the treatment.

On March 1, 1950, she was found to be five months pregnant and was delivered on August 26, of a normal infant. She has had no recurrence to date.

Discussion

There are numerous reports in the literature of Hodgkin's disease in pregnancy. One author[1] reported a case in which three normal pregnancies were consummated after the discovery of the disease. During each pregnancy, the patient was given roentgen therapy to control exacerbations of the disease. The same author obtained a report on three other cases, in two of which pregnancy seemed to aggravate the disease. One patient died three years after pregnancy, one nine years afterward, and the other was still living four years after the disease was discovered. He concluded after a comprehensive review of the literature in 1947 that Hodgkin's disease may or may not be transmitted to the offspring of a woman having the disease during the course of her pregnancy. In 33 cases collected by Bethell, Sturgis,

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 24, 1951.

Rundles and Meyers,[2] the average duration of life after the first diagnosis was twenty and three-tenths months. One patient was reported to be alive twenty years after the initial lesion was discovered.

Jackson and Barger[2] recognized three histologically and clinically distinct types of Hodgkin's disease, as follows:

1. Hodgkin's paragranuloma, mostly benign. This type has few Sternberg-Reed cells with many lymphocytes and without necrosis or fibrosis or evidence of invasion of the capsule of the gland. This has all indication of being an infectious process and is compatible with a practically normal life for many years.

2. Hodgkin's granuloma. This type has conspicuous pleomorphism, infiltration of eosinophils, necrosis and fibrosis. This is the classical type of the disease. The clinical course and type of fever suggest an infectious nature.

3. Hodgkin's sarcoma. The predominant cells are probably anaplastic. There are relatively small forms of Sternberg-Reed cells with frequent mitoses. The pathologist placed my case in the third or most malignant class.

In regard to carcinoma of the breast, Peller[3] reported an incidence of all cancer of only 4 to 6 cases in 10,000 pregnancies, which is lower than the over-all incidence. He found carcinoma of the breast to be more frequent in spinsters. Jones[4] reported 3 fulminating cases of carcinoma of the breast in pregnancy. Herrmann[5] reported that he found in the literature that the incidence of bilateral malignant disease of the breast was twice that of nonpregnant women, being 13 per cent of the total whereas the usual incidence is only 6 to 8 per cent. He noted an increased incidence of cancer of the breast in the postpartum period. My case falls into both categories; there was bilateral involvement and the disease was first discovered in the immediate postpartum period.

There are divergent views on the effects of pregnancy on the course of malignant disease although there is general agreement that a carcinoma of the breast is apt to be more fulminating.[6] Some authors, notably Haagensen and Stout,[7] classify patients in whom carcinoma of the breast develops during pregnancy as categorically inoperable and treat them palliatively with radiation because the disease is so malignant that surgery cannot cure it often enough to justify that method of treatment. They place inflammatory carcinoma of the breast in the same classification as inoperable. Many of the authors emphasized the relative frequency of inflammatory carcinoma of the breast during pregnancy. In general, however, there are less radical opinions. Jones[4] discussed the advisability of doing routine castration at the time of a radical mastectomy, but came to no definite conclusion except to state that one should at least advise against future pregnancies.

Malignant lesions of the genital tract are of course in another category and may require hysterotomy and allowing time for involution before the usually indicated radiation therapy is given.

The question of performing abortion was considered in both of my cases. The criteria used after consulting the literature and some of my colleagues were largely based on the fact that there were in each case two lives at stake, that even if the prognosis was in each case hopeless as regards the final outcome for the mother, there remained a good chance to save the child's life, and that the matter of prolonging the mother's life by an abortion was not definitely enough established to justify the procedure.

Healy[8] passed on the suggestion from Bittner that women with tumors of the breast or a history of such tumors, whether benign or malignant, should not nurse their daughters at any time.

Since in both of my cases the patient received postoperative radiation which had no apparent deleterious effect on the infants, a study was made of the reports of the effects on the fetus of roentgen therapy during pregnancy.

Giles,[9] in a review of the literature, particularly emphasized the research on the effects of roentgen rays on the fruit fly Drosophila and on mice, and noted that evidence of deformity was seldom observed in the first generation, but in the third and subsequent generations. Since, in humans, the deforming effect of roentgen rays seems to be carried as a recessive trait, it is readily understood that the first generation may not bear bad effects of irradiation, but in a second or third generation, especially after the marriage of two such recessives, some deformity might appear.

A case is cited by Dunlap[10] in which an erroneously diagnosed tumor treated by irradiation resulted in delivery of an idiot and the parents sued the physician for negligence. This author stated that injury is particularly likely when heavy irradiation is given before the third month of gestation. Microcephaly occurred in 16 of 75

cases reported by Goldstein and Murphy.[14] Dunlap[10] advised against unnecessary or repeated diagnostic exposure of roentgen rays on pregnant women. Other deformities present in the series of 75 cases reported by Goldstein and Murphy[14] consisted mostly of malformations of eyes and limbs.

In reviewing a series of 402 cases in which the patient received irradiation during pregnancy, Kaplan[11] concluded that irradiation when properly given is harmful neither to the offspring nor to the mother. There was only one abnormal child in his series. Hobbs[12] in a recent paper noted general agreement that the danger is not so great after the fifth month.

In 1936, the ruling by the two national societies concerned with heredity and racial hygiene was:[13]

1. All persons in whom there is a suspicion of radiation damage to the ovaries should have no children.

Murphy[14] analyzed 625 pregnancies in women subjected to pelvic radium or roentgen irradiation. Ill effects in varying degree included deformities, disease or weakness, stillbirth and deaths.

In both of my cases, the case of Hodgkin's disease in the fifth month of pregnancy and that of bilateral carcinoma of the breast in the first and second months, roentgen therapy was employed. The irradiation, however, was localized over the breasts and axillary regions, and both pregnancies resulted in normal babies.

Summary

Two cases are reported, one of Hodgkin's disease discovered during pregnancy and the other of bilateral carcinoma of the breast, both treated by surgery followed by roentgen irradiation. Both pregnancies were allowed to go to term with normal babies resulting. The patient with carcinoma has survived two pregnancies and remains apparently free of disease, and the patient with Hodgkin's disease had a questionable recurrence after ten months had elapsed. Although the time elapsed is too short for conclusive evidence, the 2 cases seem to bear out the philosophy that in every case of malignant disease during pregnancy, one should consider that two lives are at stake, that therapeutic abortion should be avoided, if possible, and that the effects of pregnancy on a malignant condition are not so devastating as one is sometimes led to expect. In each of the cases, the pregnancy and malignant disease were treated as two separate conditions. Roentgen therapy, when properly given, according to a review of the literature and according to these cases, is not dangerous to the first generation.

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Discussion

DR. JOHN N. MOORE, Ocala: Dr. Harrell is to be commended on the presentation of these 2 cases, and the care with which he has followed them.

Malignant lesions discovered in the breast during gestation present several problems which have been emphasized. The poor prognosis of cancer of the breast in pregnancy is due to three principal factors which it may be well to review: (1) the age of the patient, usually below 35; (2) the increased vascularity of the tissue of the breast, which favors more rapid growth and spread; and (3) the increased size of the breasts, which makes early detection difficult.

Many such cancers discovered well along in pregnancy undoubtedly began early in the period of gestation, or even prior to conception, and reach an average size of approximately 5 cm. before they are detected in a large engorged breast.

Of course radiation therapy in the breast or other regions far removed from the pelvis and abdomen does not present the risk of abortion or fetal injury as it would in a pelvic cancer where the fetus would receive perhaps a sizable dose of direct radiation.

What genetic effects from roentgen or radium therapy may result in third or fourth generation progeny of these two babies cannot be foretold. It is, however, doubtful that the dosage employed and site of treatment would produce any deleterious effect upon the germ cell.

DR. NELSON A. MURRAY, Jacksonville: I appreciate this opportunity to add a few words to the previous remarks.

In general, there is no unanimity of opinion regarding treatment of malignant disease of the breast during pregnancy. In particular, we must assume that the present cases analyzed by the essayist have been treated with sagacity for the ultimate aim has been achieved so far, namely, the patients are alive, and both were delivered of normal infants.

Since the literature regarding carcinoma of the breast is rather voluminous, my remarks will be confined to Hodgkin's disease. I would take direct exception to such

authors as Jackson and Barger, who report correlation of histologic findings and clinical course in Hodgkin's disease. I have previously analyzed 1,500 cases of malignant disease in the primary lymph nodes and have reported elsewhere 527 such cases. In these cases the diagnoses were all made without benefit of clinical history, and further study of the Hodgin's group showed no correlation between grade of malignancy and longevity. Peripheral blood studies are not diagnostic. There is no scientific proof that Hodgkin's disease is hereditary.

The case of Hodgkin's disease presently under discussion falls into the middle grade (II-III) histologically, and from a statistical standpoint there is a 15 per cent chance of the patient living five years. In closing, however, may I leave the following thought with you: No matter what the histologic grade of malignancy, the survival rate of a large group harboring the same disease cannot be driven to zero.

Fundamentals and Experiences in the Use of Refrigerated Homogenous Bone

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PENSACOLA

A bone bank enables the surgeon to shorten operative time, to avoid trauma and loss of blood, and to decrease the permanent disability of the patient. At various times in the past it has been necessary to use homogenous bone grafts for persons whose condition did not permit the removal of autogenous bone, or who, for various reasons, did not desire an autogenous graft. The ease of grafting, the satisfactory results, and the decreased disability have taught the practical value of the homogenous bone bank.

The one disadvantage of homogenous bone is that it grows 15 to 50 per cent slower than autogenous bone.[1] That homogenous bone supports growth has been thoroughly studied and taught by Phemister.[2] Since these points are well established, procuring, preserving, and using the bone in various cases will be discussed in this paper.

There are two available sources of bone, namely, (a) that removed at operation, and (b) that obtained at autopsy. The operative specimens are numerous and legally are the most desired. Ribs from thoracic surgery, extremity bone from amputations, and fragments of bone removed in any reconstruction operation should be cleaned of surrounding tissue, placed in sterile containers, labeled, dated and frozen at –10 F. to –20 F.[3]

At autopsy any piece of bone may be removed, but the iliac crest is especially valuable because of the cortical covering and its abundant cancellous layer. It is easy to remove with minimal damage to the body. Bone should be taken from patients dying of nontransferable disease as soon as possible after death.

The principles of sterile technic are essential to avoid contamination. A sterile surgical preparation is placed on the skin of the donor site. The incision is made, for example, along the crest of the ilium and the edges covered with sterile towels. The ligamentous and periosteal coverings are incised, and the entire crest is removed. After the bone is cleaned completely of surrounding tissue, it is quickly dropped into the smaller container and this jar is placed inside the larger jar (fig. 1). Freezing at –10 F. to –20 F. aids in killing bacteria that may have come in contact



Fig. 1—The wide mouth bottles allow easy removal of bone.



Fig. 2—Myelogram showing the herniated disk on the right side, and a decreased interspace. Present, but not observed, are the arthritic osteophytes on the edges of the vertebrae.

with the bone during its procurement. Bone removed at operation or amputation is handled in the same manner.

Glass containers (fig. 1) allow observation of the contents. Any particular piece of bone may then be removed. In some operations, cancellous bone is most desired, while in others, short or long cortical bone may be required. Bone from the tibial or femoral condyles has an abundance of cancellous bone, while the shaft of the tibia or femur has thick cortical bone. The ribs and iliac crests have a thin layer of cortical bone. In certain operations, such as spinal fusion, these fragments aid in filling in around the cortical pieces that will furnish the main bulk of the graft. Cancellous bone is invaded and revascularized more rapidly than cortical bone; so it is always useful and should be packed in where any opening may exist.[4]

Culturing of the bone bank should be done frequently and with accurate sterile technic. It is important to flame the tubes and transfer the small rongeured bone specimens quickly to the culture tube. If the bone is contaminated, the pieces can be sterilized by placing them in two separate ether baths and refreezing them. They must always be recultured before use.

The method of preserving bone in merthiolate was developed by Reynolds and Oliver.[5] They showed that this bone is reorganized by creeping substitution as in autogenous, synogenous, or frozen homogenous bone.

The merthiolate method is briefly as follows: Place the bone in aqueous solution of 1:1000 merthiolate for two weeks. It is then cleaned of exuberant material, cultured and placed in a 1:5000 solution of merthiolate. The bone should be placed in fresh 1:5000 solution monthly or bimonthly for cleanliness. After two negative cultures the bone may be considered ready for use. The advantages of the method are the inexpensive equipment and the simple space requirements.

Report of Cases

The following cases illustrate the use of the bone:

Case 1.—Figures 2 and 3.

DIAGNOSIS: (1) Herniated intervertebral disk between L-4 and L-5. (2) Arthritis, traumatic, at the fourth lumbar level.



Fig. 3.—H-graft between L-4 and L-5 spinous processes, not plainly seen because of enlargement.



Fig. 4 .—Tuberculosis of D-11 and D-12 with compression of the eleventh dorsal vertebra.

OPERATION: H-type bone graft to the involved interspace after excision of the disk.

HISTORY AND PROCEDURE: A 26 year old man had suffered pain in the back for several years, but recently, upon straining, he had experienced a new pain radiating down the right leg. The myelogram revealed a herniated disk at L-4 on the right side. The operation consisted of the routine removal of the disk followed by the placing of the H-graft between freshened spinous processes. The laminae were also freshened and covered with small pieces of bone. The facets were curetted. All of this donor bone was from one iliac crest.

COMMENT: The patient has a good fusion of the interspace and is symptom-free. The fusion was done without removal of autogenous bone; he was therefore less incapacitated, and there are less painful operative sites.

Case 2.—Figures 4, 5 and 6.

DIAGNOSIS: Tuberculosis of the eleventh and twelfth dorsal vertebrae.

OPERATION: Combined Hibbs and Albee fusion from D-9 to L-2 with bone bank bone from an amputated tibia.

HISTORY AND PROCEDURE: Preoperative treatment consisted of immobilizing the patient, a 46 year old woman, on a hyperextension frame. Streptomycin therapy was given for ninety days preoperatively and thirty days postoperatively. Because of her short overweight stature no external immobilization was possible. She was not permitted to bear weight until six months following fusion.

COMMENT: This amount of bone removed from the tibia or iliac crest would certainly have made the operation more shocking to this patient. The number of personnel and the time for the operation were less, for only one team was required. There is no weakened or painful donor site.



Figs. 5 and 6.—Bone graft from the bank covering D-9 to L-2, six months postoperatively. Lateral and anteroposterior views.

Case 3.—Figures 7, 8 and 9.

DIAGNOSIS: Compound comminuted fracture of the left femur.

OPERATION: Intramedullary pin with bone graft.

HISTORY AND PROCEDURE: A 65 year old frail Negro woman suffered severe multiple injuries and severe shock. The left femur was placed in balanced traction for twenty-one days, after which the open reduction was performed. The fragments of bank bone were placed about the comminuted fracture after the 9 mm. medullary pin was in place in the canal. The bone graft was held in apposition by silk suture. Metallic fixation could have been used to hold the bone graft in place.

COMMENT: The bone graft bridges the defect, insures abundance of calcium and strengthens the callus. The patient was ambulatory with aid at eight weeks following the injury and five weeks after insertion of the pin.

Case 4.—Figures 10 and 11.

DIAGNOSIS: Fracture, comminuted complete, of the lateral tibial plateau.

OPERATION: Elevation of depressed fragments, bone graft, and placing of the tibial bolt.

HISTORY AND PROCEDURE: A 34 year old truck driver was involved in an accident resulting in the fracture shown in figure 10. The fragments were elevated, and the cavity from which they came was packed with cancellous bone and match stick cortical grafts from the bone bank. This graft filled the defect and held the articular fragments up so that the bolt could lock them together. The bone graft prevented the elevated fragments from depressing when early motion was started.

COMMENT: The bone bank made it possible to avoid removing cancellous bone from the adjacent femoral condyle or the other usual donor sites. The patient was less traumatized, and his recovery was less painful.



Fig. 7.—Preoperative view of fracture of the left femur.





Figs. 8 and 9.—View three months postoperatively with the intramedullary pin and the bone bank bone incorporated in the callus.



Fig 10.—Preoperative view of fracture of the tibial plateau.



Fig. 11.—Postoperative view, showing the articular bone elevated into position, held up by bone bank cancellous and cortical chips, locked together with the bolt.

Summary

A bone bank makes bone grafting easier by saving time and personnel. The results are almost equal to those in which autogenous bone has been used, and use of bone from this source avoids further disability to the patient.

The bone is constantly available in emergencies, and there is no need for stinting on the amount of bone used. Larger operations may be performed with decreased shock and hemorrhage. The disfiguring and disabling donor sites of autogenous bone grafts have been eliminated.

Bone may be preserved by freezing or by the merthiolate technic. Sterile technic must be used at all times in handling bone bank bone. The bone is placed in glass jars, one fitting inside the other, to allow handling and still have a sterile container inside. Frequent culturing of the bone is essential to good technic.

Four varied cases are presented to show the value of the bank.

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Some Thoughts For A School Health Program

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SEBRING

School health programs are a part of nearly all general public health programs, especially in the more rural areas. Since I have the good fortune to be health officer in one of these rural areas, it seems appropriate to think a little about the school health program.

My original idea was to present observations obtained from data accumulated during school examinations performed in the Highlands-Glades-Hendry counties area by the health units there, but after looking over the statistics, I find that it will take another two years of work to present facts that would be of any value. This presentation we hope to make at a later date.

Aims

Before briefly describing the operation of our school health program, I should like to summarize the aims of most school health programs, namely (1) to maintain the students' health, (2) to prevent defects, (3) to eliminate defects when found on physical examination, and (4) to develop a health consciousness on the part of child and parent.

Planning

To accomplish anything, there must be some planning. In our department we do this during the summer months for the succeeding school year. The nurses have determined, through conferences with their respective school principals, the dates most suitable for each school. These dates are then worked out on a schedule, alloting proportionate time for each school in the area (white and Negro). This plan, we feel, helps to eliminate conflicts in our schedule when the time comes for examinations; each nurse has ample time to have her schools prepared and ready for examination; and PTA groups can have their plans and rosters for aiding ready far in advance.

Operation

All nurses in this health district visit their respective schools weekly on a regular schedule or day. They are available for consultations with teachers on these visits, and for inspection of any students referred to them at the time of their visit, but we do request that the student's health record accompany him for this inspection. The nurse records her findings on the record, and if the condition falls within the domain of the health department, the student is asked to bring his parent to the health department on the following Saturday for further consultation and examination. The majority of these referrals are either hearing or visual errors.

Physical examinations are made annually on preschool, first, third, and fifth grades throughout the area. Whether or not specified grades, or referrals only, is the wisest procedure is a controversial point which I will avoid.

The school health record is started at the preschool examination. Inasmuch as parents are required to accompany their children for preschool registration, we make the physical examination a part of registration day so that we may obtain as much information as possible regarding the health of the child in the past and determine what immunizations, if any, the child has had. This information, in addition to the height, weight and vision of the child, is determined and is recorded by the PTA aides. The child is then presented for physical examination, which is performed in the presence of the parent.

When defects are found, they are demonstrated to the parents, and the child is referred to his or her family physician and/or dentist for correction of the defects. The findings and recommendations are then recorded on the health record by the nurse, and when all examinations are completed, the records are presented to the first grade teacher, so that the record will be available when needed. This record progresses from grade to grade with the child and is kept in the student's home room to permit the teacher to make observations and record them and also to have them accessible to the nurse on her visits.

Correction of Defects

To mention briefly the number of defects per child found on our preliminary work, the first grade showed 1.20 defects per child, the third grade showed 1.25 defects per child, and the fifth

Read before the Florida Health Officers' Society, Sixth Annual Meeting, Hollywood, April 22, 1951.

grade showed 1.19 defects per child. Our percentage of corrections obtained has been far from outstanding; yet, over the three year period, it is showing an increase.

In smaller communities it is more difficult to obtain sponsors for correction of defects. In those towns having Lions Clubs, visual defects and provision for glasses are well taken care of. Other civic clubs have helped with aids for hearing defects and a few surgical procedures. We freely use the various state agencies that provide facilities and aid.

We have had far less success obtaining correction for our commonest defect. Despite the appropriation in our budget the past year for a dental hygienist, we were unable to obtain the services of one. This, I believe, is a common finding in the more rural counties.

Some Thoughts

All this we do for the child when he goes to school, but, to me, we are "missing the boat." According to the work of Cromwell,[1] 95 per cent of the babies born alive were born apparently healthy, but something will have happened to them during the first five years of their life in the following ratio:

At 2 years ..... 1.8 defects per child
At 3 years ..... 2.4 defects per child
At 4 years ..... 3.0 defects per child

Nearly all of these defects are preventable. Findings such as these are a bit alarming and call for some investigation. This was made by the American Academy of Pediatrics in 1945.[2] The findings are interesting — to quote a few: "75% of the private care of children is in the hands of the general practitioner, 11% pediatricians and 14% by other specialists." "Of 100% of children seen by the general practitioner, only 9% were well babies, 21% were sick, and 70% were persons 15 years of age and older." Again, "health supervision for the preschool child is derived from two main sources: (1) general practitioners, pediatricians, and a few other specialists, and (2) well-child conferences. Because of this dual source, a discussion of health supervision falls neither in the category of private practice nor community health services." Still quoting, "the concept of continuing health supervision for well children has become generally accepted."

Again quoting from this survey, "all children are entitled to preventive health services irrespective of the economic status of their parents. Opinion may vary about the extent to which the official health agencies should provide these services to certain economic groups. But there can be no difference of opinion about the right of every child to receive such service from either private practitioners or public health agencies. It was the ultimate objective of this study to assure that all children should receive the essential preventive, diagnostic, and curative health services of high quality." "This goal of equal health services for all children is far from attainment."

Several other brief quotations on the dental situation that I believe should be mentioned are: "Dentists are comparatively few in isolated rural areas and in the South." "The rate of dentists visits for children is least in isolated rural counties and in the South."

Conclusions

From the findings of this survey, several points become apparent:

1. The Southeastern States are lagging in child health services.

2. Pooling of knowledge from the private groups and the community agencies would provide material for proper study and mutual benefit to both. Certainly, the child would not suffer from this cooperation.

3. By focusing our attention more on the preschool child (1-5 years), with both general practitioner and health officer cooperating in developing a parental consciousness for continuing health supervision for the well child, the health of the school child should improve.

4. "Crossroads" or "grass roots" seminars in pediatrics for the general practitioner and health officer, conducted by the best teachers available, would help us to provide better preschool care. And, again, I believe that this training would improve the health of the future school child.

5. Inclusion of the dentist in the two groups mentioned would certainly add much to our information in preventing dental defects. While the feeling at present is favorable towards fluoridation of water as a prophylactic procedure, this is not so easily accomplished in the more rural areas. I am equally convinced that coca cola and candy vendors in schools should be eliminated. A satisfactory solution to the dental health problem remains to be found. There is still much work to be done.

References

1. Cromwell, Gertrude E.: The Health of the School Child, Philadelphia, W. B. Saunders Company, 1946.
2. American Academy of Pediatrics: Child Health Services and Pediatric Education, Report of the Committee for the Study of Child Health Services, 1949.

181 South Lakeview Drive.

ABSTRACTS OF MEDICAL ARTICLES

PULMONARY RESECTION FOR METASTATIC MALIGNANT LESIONS. By Hawley H. Seiler, M.D., O. Theron Clagett, M.D., and John R. McDonald, M.D. J. Thoracic Surg. 19:655-675 (May) 1950.

This article presents the findings in a study of 62 cases in which pulmonary resection was performed for metastatic malignant lesions; 52 of these cases were collected from the literature and 10 were observed at the Mayo Clinic.

Carcinoma was present in 68 per cent and sarcoma in 32 per cent of the 57 cases in which the type of primary tumor was mentioned. The primary tumors for which resection of solitary pulmonary metastatic lesions was most frequently carried out were carcinoma of the large bowel (11 cases), hypernephroma (7 cases), fibrosarcoma (7 cases), and carcinoma of the ovary (5 cases).

The time interval between removal of the primary tumor and appearance of the secondary lesion in the lung varied from zero to forty years.

In contradistinction to the former teaching that bronchial invasion by a metastatic tumor is uncommon, this study indicated that in a substantial proportion of cases (27 per cent of this entire series) the tumor will invade a major bronchus.

The type of operation performed apparently did not too greatly influence the survival rate. Lobectomy or segmental resection appeared to be the procedure of choice when possible. The operative mortality rate was 10 per cent.

At the time of the study, 23 of the 62 patients were living and well; 2 had survived ten years or longer and 7 others for periods ranging from three to ten years. The primary lesion in this group was carcinoma in 13 instances and sarcoma in 10.

It was concluded that surgical excision of solitary, metastatic, malignant lesions of the lung is indicated in certain cases in which the primary tumor has been completely removed and in which there is no evidence of further metastatic spread. Experience demonstrated that in a few instances survival for many years may be expected to follow such a procedure, while at other times the degree of palliation afforded makes the attempt justifiable.



COR TRILOCULARE BIATRIATUM: AN ANALYSIS OF THE CLINICAL AND PATHOLOGIC FEATURES OF NINE CASES. By H. Milton Rogers, M.D., and Jesse E. Edwards, M.D. Am. Heart J. 41:299-310 (Feb.) 1951.

A series of 9 cases of cor triloculare biatriatum, a relatively unusual condition wherein a common cardiac ventricle exists in the presence of two atria, is analyzed with a view to presenting a comprehensive idea as to the diversity of the pathologic and clinical features of this condition. This material represents all cases of this anomaly in the collection of pathologic specimens at the Mayo Clinic.

At death, the patients, 6 male and 3 female, ranged in age from three weeks to eight years. In 7 there was a precordial systolic murmur, at times associated with a precordial thrill. Cyanosis varied in degree. Mongolism was an associated condition in 1 patient, and isolated dextrocardia in another. Right axis deviation in 2 patients and left axis deviation in 2 was demonstrated electrocardiographically.

In 8 patients there was associated transposition of the great vessels, but, singularly, not in the ninth. In 6 of the 8, the outflow tract of the common ventricle was so divided as to create a narrow tract leading to the aorta. The pulmonary trunk was wide. In the other 2, a subpulmonary fibrous collar created a moderate degree of subpulmonary stenosis. Coarctation of the aorta was present in 2 patients, in 1 of whom tubular hypoplasia of the aortic arch between the left common carotid and left subclavian arteries also was present. This aortic abnormality existed in still another patient, but without associated coarctation.

CAROTID BODY TUMORS, CASE REPORT AND DISCUSSION. By B. P. Rentz, M.D., A. W. Wood, Jr., M.D., and D. A. Osman, M.D. South. Surgeon 16:860-869 (Sept.) 1950.

A case of tumor of the carotid body is reported. The embryology, anatomy and physiology of this body are discussed. The literature on tumors of the carotid body is reviewed, and the various aspects of the subject, including the pathology, histology, diagnosis, and therapy, are presented.

The authors concur in the opinion of most investigators that these tumors should not be classified among the so-called chromaffin tumors. They were unable to establish in their case a relationship between the neoplasm and the pericytes (Zimmerman).

THE CEREBRAL EFFECTS OF PAPAVERINE HYDROCHLORIDE IN TOXEMIA OF PREGNANCY. By Milton L. McCall, M.D., T. Vernon Finch, M.D., and Harry W. Taylor, M.D. Am. J. Obst. & Gynec. 61:393-398 (Feb.) 1951.

The study here reported offers evidence that papaverine hydrochloride, a comparatively nontoxic opium derivative causing relaxation of smooth muscle by direct action, has a pronounced effect in patients suffering from the nonconvulsive toxemias of pregnancy. With the use of the nitrous oxide method of Kety and Schmidt, the cerebral blood flow and related circulatory and metabolic functions of the brain were investigated both before and after the administration of this drug to a group of women with pre-eclampsia and hypertensive toxemia of pregnancy. Significant lowering of the mean arterial blood pressure and favorable alteration of certain aspects of cerebral physiology were noted. There was remarkable and rapid lowering of the typically elevated cerebral vascular resistance to the normal range. The increase of cerebral blood flow was significant, as was the increase in the oxygen utilization by the brain.

After discussing the possible value of this drug in toxemia of pregnancy, the authors conclude that it should be given a fair clinical trial as an adjunct to the therapy of this disease.

SPONTANEOUS RUPTURE OF THE ESOPHAGUS. By M. Eugene Flipse, M.D. Dis. of Chest 19:165-192 (Feb.) 1951.

In this comprehensive article the author defines and classifies spontaneous rupture of the esophagus, one of the rarer yet more dramatic conditions for which the recent advances of thoracic surgery and antibiotic therapy have offered a means of definite treatment and cure. He then discusses the pathogenesis of rupture, etiology, pathology, clinical aspects, differential diagnosis, radiologic aspects, thoracentesis findings and treatment.

Rupture occurs chiefly in association with vomiting and/or retching, alcoholism and diseases of the central nervous system. Definite diagnosis is possible by observing radiologically the passage of radiopaque medium through the rent into the mediastinal and pleural spaces or by aspiration of stomach contents from the pleural space. The treatment of choice in the early cases is prompt transpleural repair of the rent. The most important of the supportive measures are the decompression of any tension pneumothorax or high pressure mediastinal emphysema, and the use of antibiotic therapy.

Two cases, with autopsy, are added to some 100 in the literature. Of this number there was survival in but 13, all reported since 1938, 10 since 1946. The various surgical procedures employed in the 13 cases of survival are discussed.

NEW APPROACH FOR SUBTROCHANTERIC AND UPPER FEMORAL SHAFT FRACTURES USING A DUAL FLANGE NAIL PLATE, A PRELIMINARY REPORT. By Eugene L. Jewett, M.D. Am. J. Surg. 81:186-188 (Feb.) 1951.

A new and promising method with the use of a dual flange nail plate is described for the treatment of the upper femoral shaft and subtrochanteric fractures of the femur. As a technical procedure it is not difficult. No plaster cast or immobilization is necessary, and only in a few instances will a week or two in Buck's extension be advisable.

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VOLUME XXXVIII
NUMBER 5

The Journal of the Florida Medical Association

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November Anniversaries

NOVEMBER 2. The first medical treatise printed in the English colonies was titled "A Brief Rule to Guide the Common People of New England How to Order Themselves and Theirs in the Small Pocks or Measles." Printed in Boston on Nov. 2, 1677, it was written by Thomas Thacher, the first minister of Old South Church and also a physician. The treatise indicates that the colonists believed the epidemics which swept neighboring Indian tribes were interventions of Providence to protect the struggling white men.

NOVEMBER 7. Marie S. Curie of Poland and Paris, France was born on Nov. 7, 1867. A quiet, unassuming woman, she overcame handicaps of hardship which seem almost insurmountable today, to become the brilliant chemist of her era. In addition to doing her own household work and serving as an instructor in a girl's school, she worked hour after hour with her husband, Pierre, in a leaky shed which they called their laboratory. Together they must have handled about four tons of pitchblende, the common source of radioactive uranium, in order to obtain by fractional crystallization a minute quantity of the new element radium. At the present time, even more than a few decades ago, we can appreciate the work of this renowned chemist and her skilled physicist husband, because it led to our entirely new concept of the relation of matter to energy, and to a new field in science, atomic physics, which split the atom and set us down abruptly in the midst of the "atomic age."

The Nobel Prize was awarded to Marie and Pierre Curie jointly in 1904 and again to Madame Curie in 1911. This is the only instance of a second award to the same person.

NOVEMBER 11. Ephraim McDowell was born on Nov. 11, 1771. After studying medicine in Edinburgh, he became a frontier surgeon in Kentucky. On Christmas Day in 1809, he performed the first ovariotomy on a Mrs. Jane Todd Crawford.

NOVEMBER 14. The Pasteur Institute in Paris, the first of a large number of its kind now located throughout the world, was opened with impressive ceremonies on Nov. 14, 1888. Louis Pasteur was so moved by the honors paid him from far and wide that he was unable to deliver the address which he had prepared. The address, read by his son-in-law, was closed with these words:

> Science, in obeying the law of humanity, will always labor to extend the frontiers of life.

NOVEMBER 17. Hans Zinsser of Boston was born on Nov. 17, 1878. Graduate of Columbia University in both arts and medicine, he held the chair of bacteriology at Leland Stanford, then

Columbia and finally Harvard Medical School. He became well known for his work in Rickettsia diseases, his work in typhus fever having become popularized and glamorized by his widely read book, "Rats, Lice, and History." His textbook of "Bacteriology and Infection and Resistance" was standard with discriminating students both young and mature for many years.

With great natural ability, good family background and financial backing, Hans Zinsser developed into a charming person, gay, voluble and keen — a judge of good horses and wine. Those few people who did not admire him seem to have been nettled by his lack of tolerance. One writer has said, "He was one of the persons on whom all controversial questions of his time acted like horse-flies on a half broken mule."

Learning that he would soon die of leukemia, Zinsser set about the writing of his autobiography as if it were written by someone else after his death. That autobiography, titled "As I Remember Him" and published shortly before he died in 1940, has been widely read and enjoyed.

Science in the News

Medicine and public health hold top interest for newspaper editors as subjects for science writing. A recent survey, covering 150 newspapers in the United States, disclosed that managing editors, generally, are satisfied with both style and length of the science news stories they now receive. Only limitations of space prevent many of them from using even more items.

Most of the editors who responded to the eight-point questionnaire, sent out by the National Association of Science Writers in cooperation with the New York University Department of Journalism, were of the opinion that the amount of space allotted to science has doubled during the past decade. Too, the trend toward a regular staff member assigned to handle science news is growing. Approximately one third of the editors reported that at least one staff member devotes a major portion of his time to this type of work.

Medicine and public health news is the favorite field of special news interest, but stories on atomic energy are regarded as almost as good for news play. The former ranked first with 41 of the editors who replied, and prime interest in the latter was a close second with 38 others. Among other favorites were stories in which the newspaper reader could identify himself, such as new inventions for the home and news on agricultural science.

Relative Rise in Medical Care Prices

The price of medical care, including drugs, hospital room rates and physician and dental services, was relatively cheaper by 14 per cent in 1950 than during the 1935-1939 base period, according to the Consumers' Price Index. This index, compiled by the United States Bureau of Labor Statistics, measures monthly the changes since 1935-1939 in the prices of fixed quantities of goods and services normally purchased by families of moderate income in large cities and is considered the best general measure of the purchasing power of the consumer's dollar.

The price of medical care has risen only 48 per cent since 1935-1939, the government figures show, but the general cost of living has risen 72 per cent. For every $1 paid for goods and services generally in 1935-1939, the consumer in 1950 had to pay $1.72. Nevertheless, the medical care purchased for $1 in that base period cost only $1.48 in 1950.

Analysis of the index discloses further that $1 in 1950 could buy 68 cents worth of medical care, but only 58 cents worth of all goods and services, or 86 per cent as much. In 1950 the purchasing power of the dollar was 86 per cent as high in terms of goods and services, generally, as it was in terms of medical care prices only. Thus, in terms of the purchasing power of the 1950 dollar, medical care was relatively 14 per cent cheaper than in 1935-1939.

Physicians' fees, the index indicates, rose 40 per cent, or only slightly more than half as rapidly as the entire cost of living, which rose 72 per cent.

Hospital room rates are the only item which has risen faster than the entire Consumers' Price Index. Increasing by 135 per cent, the high hospital rates reflect the fact that "hospitals are singularly exposed to the forces of inflation," as pointed out in a careful study of the index by the Bureau of Medical Economic Research of the American Medical Association.[1]

The increase for food, the index shows, was 104 per cent; apparel 88 per cent; rent 31 per cent; fuel, electricity and refrigeration 41 per cent; house furnishings 90 per cent, and miscellaneous items 57 per cent. All rose more rapidly than medical care prices except two, the item of rent and the item of fuel, electricity and refrigeration.

1. Dickinson, F. G.: Medical Care Prices and the Cost of Living, J. A. M. A. 147:258-259 (Sept. 15) 1951.

British and Swiss Medicine: A Warning and an Example

Recent editorial comment in the British Medical Journal frankly and bluntly painted a dark picture of bankruptcy because of the Utopian finances of the Welfare State and, for the profession, bankruptcy of a policy because of governmental decisions during a war for survival executed by a Minister of Health, now resigned, "who could not resist the temptation to behave like a Fairy Godmother to an impoverished nation. . ."

Unfulfilled promises on both the medical and economic fronts add up to the spectacle of bankruptcy of a policy in both the general medical services and consultant services. "And what must astound the historian of the future is the failure in what is termed a 'Health Service' to enlarge and encourage the Public Health Service, the members of which have perhaps had the hardest knock of all."

The public at large welcomes the limited benefits — "principally, perhaps, the benefit of not having to pay directly for medical aid at the time of receiving it. . . . The shocking waste of public money over the inessentials of medicine has left little over for what is more urgently needed. . ."

The editorial[1] ascribes the failure to provide a fully comprehensive health service and to fulfil the obligations to the medical profession to "the economic mess that has come from appearing to promise the people of the country something for nothing. . . .The medical profession is discontented and disillusioned, not because of payment, or lack of it, for this or that, but because it sees postponed indefinitely the opportunities for improving the medical care of the people." Britain appears to offer to the people of the United States the supreme example of how not to fetter a free medical profession here.

In contrast is this forthright declaration from the heart of troubled Europe: "Under the sign of absolute liberty, the state having not yet interfered, the Swiss physician is very equal to his task." Dr. Leon Weber-Bauler, the venerated 81 year old editor of "Medicine and Hygiene," a popular medical newspaper published in Geneva, recently provided Dr. Elmer L. Henderson with this and other interesting sidelights on the practice of medicine in Switzerland.

Many young practitioners undergo such prolonged training that they do not begin the practice of medicine before their thirties, most of them becoming specialists. Practice in collective groups, such as clinics, remains the exception in that land famed for its high number of private hospitals and clinics, apart from the state ones.

The five big faculties of medicine in the country keep abreast of medical science. Most of the members speak French, German and English fluently, thus benefiting from medical society meetings in many foreign countries.

The big cities have several private laboratories for biologic analysis, and radiologists are numerous.

Switzerland now has approximately 4,500 practitioners of medicine, exclusive of assistants and interns, making one physician for each 1,000 inhabitants. May this bastion of medical freedom remain as impregnable as the Alps which form the setting for it, the while serving as an example to the United States and the world.

1. British Medical Journal Supplement, Dec. 2, 1950, p. 224.

World Medical Association Progress

At the Fifth General Assembly of the World Medical Association, held in Stockholm in September, Dr. Elmer L. Henderson turned over his presidential duties to Dr. Dag Knutson of Sweden. In reviewing briefly the highlights of the association's progress during his year in office, he reported a steady forward movement toward the goal of an eventual membership representing 60 nations and 500,000 physicians throughout the world.

Also, there was important progress during the year in building constructive relationships with the World Health Organization and other groups concerned with international activities in the field of medicine and health. A major topic of discussion with the WHO was the possibility of holding an international conference on questions of professional and technical education. Tentative plans for such a conference are to be submitted to the governing bodies of the WHO and the WMA. The purpose of the conference would be to stimulate the improvement of standards of training for medical and related personnel, a problem considered essential by both organizations.

Headway toward closer cooperation and coordination, to which Dr. Henderson could also point with pride, was made in discussion of: "measures to promote the free flow of essential medical supplies between countries, and to ease the difficulties caused by shortages resulting from the present world situation . . . assistance to be given to the

World Health Organization by the World Medical Association in the selection of suitable experts for work in various specialized fields . . . exchange of information and documentation on subjects of common interest, and contributions by each organization to the publications of the other . . . cooperation of the World Medical Association in assuring the widest possible adoption of international, nonproprietary names recommended by the World Health Organization for drugs and pharmaceutical products, with due recognition of recommendations by the discoverers of the products . . . assistance from the World Health Organization, through its various publications, in making known the International Code of Medical Ethics adopted by the World Medical Association . . . and representation of the World Medical Association in regional conferences of the World Health Organization."

The Voice of Labor

With Oscar Ewing's huge propaganda machine in behalf of socialized medicine slowed down by The Congress, it appears that William Green, the president of the American Federation of Labor, has taken up the cudgel. He recently made a full page appeal in his organization's publication "The American Federalist," to "all our 8,000,000 members and their families" to contribute to the Committee for the Nation's Health. The burden of his message was:

> At the Houston convention last September, we of the American Federation of Labor pledged ourselves to a continued fight for national health insurance, disability insurance and federal aid to train more doctors and strengthen local public health departments.
>
> Determined to block these necessary and desirable measures, the American Medical Association has been spending millions of dollars in the last two years. The medical lobby is a spearhead of the reactionary forces.
>
> We of the American Federation of Labor are determined to preserve and extend our hard-won gains in social security, health and welfare. In this important activity our invaluable ally is the Committee for the Nation's Health, a group of distinguished physicians and laymen. The Committee for the Nation's Health is working hard to aid the American Federation of Labor and Labor's League for Political Education to build the solid educational base for a mandate to achieve labor's health goals.
>
> Every contribution to the Committee for the Nation's Health will help defeat the medical lobby's lies at the grass roots. Your contribution — large or small — to this Committee will pay off in better health and welfare legislation for all our 8,000,000 members and their families.

In view of this powerful new effort toward socialization, there is particular significance in the increased demand for reprints of "Socialized Medicine Is No Bargain," by William L. Hutcheson, who is general president of the United Brotherhood of Carpenters and Joiners of America and vice president of the American Federation of Labor, and of "Government Medicine — Danger Ahead" by Dave Beck, the executive vice president of the International Brotherhood of Teamsters. The Hutcheson article was commented upon editorially in the February 1951 Journal. This demand appears to indicate that the rank and file of working people are realizing that nationalization of the medical profession would give them only politically controlled medical care, the antithesis of the better and cheaper medical care its proponents so brashly promise.

In response to "thank you" letters, Mr. Beck gave as his reason for speaking out boldly in behalf of free medicine in this country at the recent meeting of the American Medical Association at Atlantic City the following: "I was actuated not only by my hatred of communism, but also by my deep admiration for the medical profession, individually and collectively. If we — the International Brotherhood of Teamsters — have anything to do with it, and I think we will, our American Way of life and our free enterprise system will endure for a long, long time. I hope I have been able to make some small contribution to the cause which is very dear to the hearts of all freedom-loving Americans."

Health Insurance Council Report

The 1950 report of the Health Insurance Council, issued in September, should offer supporters of socialized medicine plenty of food for thought. This Council comprises nine trade associations in the life and casualty fields.

At the end of last year, the report shows, at least half of the population of the country was covered by some type of voluntary protection against the economic hazards of sickness and accident. All forms of voluntary health protection set new records by scoring tremendous gains in 1950.

The largest number of people have hospital expense protection. At the close of the year this coverage was extended to 76,961,000 persons. This total was 17 per cent greater than the figure of 66,044,000 only a year before. The public's growing appreciation of the advantages of voluntary health protection is reflected in the fact that the number of persons protected against hospital costs has more than doubled since the end of World War II.

Surgical expense and medical expense coverages also made great strides in 1950. There was an in-

crease of 32 per cent in protection against surgical expense, the number covered growing from 41,143,000 to 54,447,000 within the year. The gain recorded for medical expense protection was 28 per cent, with coverage for 21,589,000 in 1950 and 16,862,000 in 1949. Both surgical and medical coverages also have shown larger postwar gains. In each case, the 1950 figures more than quadruple the 1945 totals.

Any physician who desires a copy of the complete insurance report may receive it upon request to the Council on Medical Service of the American Medical Association.

A.M.A. Clinical Session Los Angeles, December 4-7

When the 1951 Clinical Session of the American Medical Association convenes in Los Angeles early next month, postgraduate study designed for the general practitioner will be the theme of the meeting. A broad presentation of clinical studies on problems encountered by the general practitioner in daily practice, with stress on therapy, will be featured. In addition, subjects of interest to the specialist will be presented, and practical clinical discussions, scientific exhibits and general lectures on basic problems also are planned.

Opening on December 4, the four day scientific program covers a wide range of subjects having broad appeal. Coupled with the emphasis on general practice, there will be discussions and presentations on general surgery, industrial medicine and surgery, internal medicine, cardiovascular diseases, diseases of the chest, urology, ophthalmology, otolaryngology, neuropsychiatry, radiology, obstetrics and gynecology, dermatology, pediatrics, pathology, anesthesia, medical banks, and traumatology as related to civil defense.

One of the highlights among the many attractions will be color television to demonstrate surgery, clinical treatment and examination procedure. Scientific exhibits on cancer, diabetes, heart disease, obstetrics and gynecology, pediatrics, internal medicine, surgery, dermatology and other subjects will be an added attraction. Too, the opportunity to confer personally with the qualified attendants representing the 165 firms having technical displays will aid physicians in solving many troublesome problems.

Both the scientific and the technical exhibits will be located in the Shrine Convention Hall, adjacent to the Al Malaikah Temple, where the lectures, clinical presentations, television reception and motion picture showings will take place.

Wanted

With the permission of the editor, Mrs. Nelson Murray of Jacksonville, an excerpt from the Florida Medaux, official organ of the Woman's Auxiliary to the Florida Medical Association, is reproduced below. The editor gives no inkling as to what is being done to comply with the request.

Early this summer all the doctors in Florida received a double postcard requesting help in securing the correct address of their respective wives. As was to be expected, the card was innocently sent to a few unmarried physicians. Most bachelors either ignored the card entirely — or wrote a brief note to enlighten us of his "free" status — that is, all but this one. The original card read:

Dear Doctor:
Will you of your valuable time, —
Pause long enough to fill in this line.
Your home address is the item we require
To send your wife The Medaux is our desire.
To have her informed of all our work
Is a duty we do not wish to shirk.

By crossing out and changing a key word here and there, this doctor easily twisted the little rhyme to read back:

Dear Madam:
I Will, of my valuable time, —
Pause long enough to fill in this line.
My home address is the item you require
To send me a wife, Medaux, is my desire.
It is a duty I do not wish you to shirk.
—Florida Medaux

Simplified Insurance Reporting Forms

Short and relatively simple insurance reporting forms have been developed for the attending physician's statement. The forms are known as "Attending Physician's Statement — Accident" and "Attending Physician's Statement — Sickness." These forms were developed by the Health and Accident Underwriters Conference in collaboration with the International Claim Association. They have been approved by the collaborating organizations, the National Association of Insurance Com-

missioners and the A.M.A. Council on Medical Service.

Similar forms for requesting hospital information have been developed by the Conference and the International Claim Association. The hospital report forms have been approved by the collaborating organizations, the National Association of Insurance Commissioners and the American Hospital Association.

The simplified forms are the result of considerable study by the interested organizations to develop a form which would provide the insurance company with adequate information and yet would not require a great amount of time in filling out by the attending physician. Specimen copies of these forms are available to any physician upon request to the Council on Medical Service, American Medical Association, 535 North Dearborn Street, Chicago 10.

Diabetes Detection Drive

The 1951 Diabetes Detection Drive will be launched by Diabetes Week, November 11-17, and promises to be one of the most extensive yet sponsored by the American Diabetes Association. This annual Drive, which has been approved by the American Medical Association for three consecutive years, is the only broad health education and case-finding program developed exclusively by the medical profession. Participation in this program offers physicians a unique opportunity to conduct a constructive public relations program and, at the same time, to perform a genuine public service.

The American Diabetes Association, composed primarily of physicians deeply concerned with the diabetes problem, promulgates a continuous, year-round Diabetes Detection Drive, directly sponsored and conducted by local physicians through their medical societies and the local diabetes associations. Designed to further the detection of the disease in the general population and at the same time to disseminate information concerning diabetes, it is spearheaded annually by Diabetes Week. At that time concentrated detection and testing programs are organized on the community level.

Some 28 state medical societies and approximately 500 county medical societies have already set up committees on diabetes whose primary function is to conduct diabetes detection programs in their respective areas. One hundred per cent cooperation of all state medical societies is the goal of this year's program.

Diabetes may be aptly defined as the disease of complications, since so many other ailments find the diabetic person a particularly easy prey. Since the physician must not only supervise the treatment of patients in whom diabetes has been diagnosed but must also discover the persons in whom the disease is hidden, it is of prime importance that the broad diabetes detection program be placed firmly in the hands of the medical profession, working through the organized medical societies.

Southeastern States Cancer Seminar Orlando, November 28-30

Orlando will be host to the 1951 Southeastern States Cancer Seminar on the last three days of this month. This fifth annual meeting, opening on November 28, will be held at the San Juan Hotel.

On Wednesday morning, Dr. Milton R. Porter will lecture on "Current Considerations in Surgery," summarizing the most recent advances in treatment and palliation. There will follow a panel discussion on "Cancer of the Prostate and Bladder," and in the afternoon the panel discussion will deal with "Gynecological Cancer."

"Current Considerations in Chemotherapy" will be the subject presented by Dr. Alfred Gellhorn on Thursday morning. A panel discussion on "Lymphomas and Blood Dyscrasias" will conclude the morning session, and in the afternoon "Cancer of the Breast" will be the subject for panel discussion.

In the lecture on Friday morning, entitled "Current Considerations in Radiotherapy," Dr. Vincent P. Collins will review the most recent advances in treatment and palliation. "Cancer of the Head and Neck" will be the subject of the panel discussion which will follow. At the final session that afternoon, "Cancer of the Gastrointestinal Tract" and "Cancer of the Lung" will be the subjects for panel discussions.

All speakers have given assurance that in the panel discussions they will stress: (1) possible new methods of cancer detection and/or treatment; (2) palliative measures for the incurable patient; (3) pitfalls and errors of diagnosis and treatment of malignant disease; and (4) problem cases. The program, therefore, should be of unusual interest and particularly stimulating to all physicians of Florida and the neighboring states who are privileged to attend.

The faculty comprises the Staff of the Francis Delafield Hospital, New York City. These distinguished teachers, all members of the faculty of Columbia University College of Physicians and Surgeons, include: Dr. Collins, Associate Professor of Radiology; Dr. Gellhorn, Associate Professor of Clinical Cancer Research, Department of Medicine; Dr. Cushman D. Haagensen, Associate Professor of Clinical Surgery; Dr. Perry B. Hudson, Assistant Professor of Urology; Dr. Herbert B. Maier, Assistant Clinical Professor of Surgery; Dr. Joseph J. McDonald, Professor of Surgery; Dr. Porter, Instructor in Surgery; Dr. Arthur P. Stout, Professor of Pathology; and Dr. Gray H. Twombly, Assistant Professor of Clinical Obstetrics and Gynecology.

Sponsored by the Florida Division of the American Cancer Society and the Florida State Board of Health with the cooperation of the Florida Medical Association, this annual Seminar has been enthusiastically received since its inception in 1947. The Orlando meeting promises to be equally successful. Reservations may be made by writing the Southeastern States Cancer Seminar, San Juan Hotel, Orlando, Fla.

Florida Heart Association

The Florida Heart Association, with headquarters in St. Petersburg, recently completed a program of professional education and service. This program began in May and extended into September. An important phase of the project was the distribution of charts, pamphlets and booklets to selected groups of physicians throughout the state.

There have come to the attention of the Journal two booklets and one chart made available by the American Heart Association. One booklet, "Examination of the Heart" was distributed primarily to internists. A somewhat smaller booklet on "Standardization of Blood Pressure Readings," together with a chart on "The Classification of Patients with Diseases of the Heart," was distributed to general practitioners in the state. Any physician interested in obtaining any of this literature is requested to contact the Florida Heart Association, P. O. Box 587, St. Petersburg 1, or their local chapter if one has been organized.

Association members included among the officers of the Florida Heart Association are Drs. Elwyn Evans of Orlando, president; Jere W. Annis of Lakeland, president-elect; Norman E. Williams of Daytona Beach, vice-president and H. Milton Rogers of St. Petersburg, secretary.

Members of the executive committee in addition to the officers include Drs. Louie Limbaugh of Jacksonville, E. Sterling Nichol of Miami and Alvin E. Murphy of Palm Beach. Comprised of both physicians and laymen, other members of the executive committee are J. Hardin Peterson, chairman of the board, E. Russell Sheldon, Jere L. Stambaugh and John L. Rudd, executive secretary.

Medical Licenses Granted

Dr. Homer L. Pearson, Jr., Secretary of the State Board of Medical Examiners, has reported that of the 237 applicants who took the examination of the Board, held June 25 and 26, 1951 in Jacksonville, 213 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 213 successful applicants follow:

Adelson, Bernard Henry, Tampa (Northwestern 1951)
Ahmann, Helen Marie, New Orleans, La. (Tulane U. 1951)
Aliff, Robert Carl, Tampa (Med. Col. of Va. 1943)
Andrews, Carl Edwin, Chicago, Ill. (Yale U. 1944)
Andrews, Robert John, Cincinnati, Ohio (U. of Cinn. 1951)
Atkins, James Thomas, Warrington (Med. Col. of Ga. 1951)
Attyah, Albert M., Laurel, Miss. (Med. Col. of Ga. 1945)
Austin, Grover Wiggins, Memphis, Tenn. (U. of Tenn. 1944)

Baldwin, Allan Akins, Athens, Ohio (U. of Cinn. 1936)
Bane, Russell Clyde, Chillicothe, Ohio (Ohio State U. 1935)
Barr, James Ray, Jacksonville (U. of Tenn. 1944)
Bartlett, Willard, Jr., St. Louis, Mo. (U. of Mich. 1926)
Bashford, Margaret, Pelham Manor, N. Y. (Cornell U. 1941).
Batten, Hubert Elmore, Portsmouth, Va. (Med. Col. of Va. 1951)
Bell, Jack Emory, Augusta, Ga. (Med. Col. of Ga. 1943)
Biber, David, Union, N. J. (Eclectic Med. Col. Cinn. 1939)
Bindshedler, Buell, Jackson, Miss. (Wayne Col. 1940)
Blackford, Ralph Ellis, Miami (Indiana U. 1934)
Boyd, Charles Glenn, New York, N. Y. (U. of Toronto 1936)
Bozeman, James David, Andalusia, Ala. (Med. Col. of Ga. 1950)
Bray, Walter Abner, St. Petersburg (Tufts U. 1932)
Brock, Roy Crawford, Decatur, Ga. (Emory U. 1951)
Brownstein, Jacob Morris, Brooklyn, N. Y. (Geo. Wash. U. 1927)
Brumback, Clarence Landen, West Palm Beach (U. of Kan. 1943)
Brungard, Elizabeth Ann, LaBelle (U. of Buffalo 1942)
Burns, David Nanson, Tampa (Northwestern U. 1949)
Burns, Edward Clyde, Jr., Lake Wales (Emory U. 1946)
Burns, Francis Joseph, Jr., St. Petersburg (Emory U. 1951)
Burt, John Elmer, Jacksonville (U. of Texas 1950)

Campbell, John Edgar, Jr., Knoxville, Tenn. (U. of Tenn. 1946)
Carter, Gerard F., New York, N. Y. (Italy 1938)
Cassidy, Francis Patrick, Pensacola (La. State U. 1944)

Chandler, Howard Christy, Jacksonville (Emory U. 1951)
Cheney, George P., New London, Conn. (U. of Md. 1913)
Christensen, Eldis Marvin, Lagrange, Ill. (U. of Ill. 1946)
Christoffers, Donald Murray, Keystone Heights (Emory U. 1951)
Clark, Spurgeon William, Jr., Greensboro (Emory U. 1951)
Coggins, Deborah Reed, Tampa (Duke U. 1951)
Coggins, Wilmer J., Tampa (Duke U. 1951)
Cole, Lee Marion, Jr., Christianburg, Va. (Duke U. 1943)
Collier, John Elwood, Richmond, Va. (Med. Col. of Va. 1931)
Collins, Clyde Mabry, Jacksonville (U. of Ga. 1942)
Cox, Arlo Kenneth, Marianna (U. of Okla. 1932)
Creel, Frank Lamar, Pensacola (Wake Forest Col. 1948)
Crews, Marjorie Anne, Jackson Heights, L. I., N. Y. (New York U. 1944)
Cutler, Edward, Miami Beach (Hahnemann Med. Col. 1949)
Dance, Clifton Louis, Jr., Ft. Lauderdale (Wayne U. 1943)
Davis, Floyd Millard, VanVleet, Miss. (U. of Tenn. 1941)
Derrick, Walter Ansell, Orlando (U. of Va. 1932)
DiLorenzo, Ernest E., Brooklyn, N. Y. (Col. of P. & S., Kansas City 1938)
Dishner, Paul Frederick, Miami (U. of Tenn. 1950)
Dortch, Hugh, Jr., Durham, N. C. (Duke U. 1945)
Emlet, John Richard, Durham, N. C. (Duke U. 1945)
Everts, William H., New Rochelle, N. Y. (U. of Mich. 1932)
Faget, Frank Marie, Melbourne (Tulane U. 1911)
Farley, Albert Walter, Jr., Bay City, Mich. (Duke U. 1947)
Feldstein, Morris, New York, N. Y. (New York U. 1940)
Fink, Joseph Louis, Detroit, Mich. (U. of Mich. 1944)
Folsom, John Henry, Jr., Winter Park (Emory U. 1951)
Frame, Eugene Martin, Jacksonville (Temple U. 1942)
Frazier, Truett Hollis, Asheboro, N. C. (Duke U. 1944)
Freeman, Oscar William, Atlanta, Ga. (Emory U. 1951)
Gilbert, J. C., Jr., Miami (U. of Tenn. 1951)
Goldstone, Sidney Richard, Tampa (U. of Ill. 1947)
Gonzalez, Manuel Ambrosio, Miami (Havana U. 1944)
Gordon, Minerva, Attleboro, Mass. (Middlesex Col. 1927)
Grau, Harry Robert, Daytona Beach (Ohio State U. 1934)
Greene, John Patterson, Jacksonville (Duke U. 1950)
Griffin, John Mettauer, Quincy (Emory U. 1951)
Grisinger, George Floyd, Jr., Miami (Jefferson Med. Col. 1942)
Guyton, Thomas Bryan, Miami (Tulane U. 1951)
Gyland, Stephen Paul, Tampa (Vanderbilt U. 1951)
Handwerker, John Valentine, Jr., Miami (U. of Tenn. 1950)
Hartsfield, Richard Campbell, Orlando (Med. Col. of Ga. 1951)
Helton, William Stacer, Miami (U. of Ga. 1949)
Hernandez, Francisco Adriano, Miami (Columbia U. 1933)
Holmes, Claude Duvall, Jr., Frankfort, Ind. (Indiana U. 1944)
Howard, Royal Marwin, Miami Beach (New York U. 1945)
Jeffress, Jessie Elizabeth, Tampa (Women's Med. Col. of Pa. 1949)
Jimenez, Manuel Eugene, Pensacola (Havana U. 1941)
Johnson, Henry Cecil, Jr., Atlanta, Ga. (Emory U. 1951)
Jones, Frederick Boone, Marianna (Tulane U. 1950)
Kaufman, Harry, Chicago, Ill. (U. of Ill. 1946)
Kay, John Howard, Panama City (Yale U. 1943)
Kelley, Edmund Parmelee, Brandon, Vt. (Harvard U. 1942)
Killian, Edgar W., Miami Beach (Loyola U. 1944)
Kilmark, Robert M., Boynton Beach (Med. Col. of Ga. 1950)
LaGuette, Henry Firmin, Orlando (Mexico 1948)
Lamb, William Eugene, Jacksonville (U. of Md. 1951)
Larkin, Matthew A., Miami (Albany Med. Col. 1944)
Laviano, Trent, Tampa (U. of Va. 1949)
Leder, Harold Leon, New York, N. Y. (New York U. 1939)
Lee, Aubrey Bernard, Opp, Ala. (Vanderbilt U. 1932)
Lehmann, Albert, West Point, Ga. (Med. Col. of Ga. 1951)
Lenzen, John Louis, Webster Groves, Mo. (Wash. U. 1949)
Lester, Robert Harrison, Wadley, Ga (Med. Col. of Ga. 1951)
Lewis, Edward Conrad, II, Warrington (U. of Pittsburgh 1949)
Liebler, John Baxter, Coral Gables (Temple U. 1945)
Loftis, Warren Thomas, Jr., Orlando (Emory U. 1951)
LoPinto, Francis Joseph, Miami (Loyola U. 1936)
McCorkle, Albert Wilson, Lake Worth (Col. of Med. Evangelists 1950)
McDermid, Howard Calvin, Vidalia, Ga. (Med. Col. of Ga. 1951)
McKay, Charles Ferrebe, Macon, Ga. (Med. Col. of Ga. 1950)
Mack, Clifford Hayes, Wayne Co., Pa. (U. of Pittsburgh 1931)
Majzlin, Gregory, Brooklyn, N. Y. (New York Med. Col. 1939)
Manchester, Gordon Charles, Gainesville (Temple U. 1950)
Manni, Lawrence Charles, Marianna (U. of Mich. 1935)
Marks, Charles H., Albany, Ga. (Vanderbilt U. 1951)
Marsh, John Gustin, Greenville, Miss. (Col. of Med. Evangelists 1939)
Marques, Vincent Horres, Lake Village, Ark. (U. of Ark. 1950)
Massam, Alfred Sydney, Bartow (Col. of P. & S., Boston 1947)
Menendez, Raymond, Tampa (La. State U. 1946)
Milam, Daniel Franklin, Jr., Jacksonville (Harvard U. 1948)
Millard, David Ralph, Jr., Houston, Tex. (Harvard U. 1944)
Miller, Knox Emerson, Jacksonville (Johns Hopkins 1912)
Moersch, Robert Urban, Rochester, Minn. (U. of Pa. 1944)
Moody, James Donaldson, Orlando (Duke U. 1944)
Morales, Beatrice Eleanor, Miami (Tulane U. 1951)
Morris, Douglas Cockerille, Manassas, Va. (Geo. Wash. U. 1950)
Murphy, Ian Douglas, Ensenada, P. R. (Hahnemann Med. Col. 1943)
Myers, Andrew Lewis, Jr., Sanford (Temple U. 1951)
Nathanson, Florence, Miami (New York U. 1935)
Neel, Julian Blackburn, Thomasville, Ga. (Emory U. 1943)
Nevel, Harry A., Jacksonville (U. of Mich. 1938)
Newman, Alex, New Orleans, La. (Chicago Med. School 1949)
Odom, Corely Walton, Irondale, Ala. (U. of Tenn. 1943)
O'Donnell, John Alphonsus, Jacksonville (Georgetown U. 1945)
O'Neill, John Brooks, St. Petersburg (U. of Va. 1918)
Ormond, Anthony Milton, Amarillo, Tex. (Baylor U. 1945)
Palfrey, William Gorgas, Baton Rouge, La. (Tulane U. 1945)
Palmer, Margaret, Ocala (Emory U. 1951)
Park, Charles Lanier, Jr., Jacksonville (Emory U. 1951)
Pearce, Charles Gerald, Miami (U. of Ark. 1944)
Pendleton, Horace Bennett, Hartford, Ky. (U. of Louisville 1950)
Pennington, Thomas Guy, Brentwood, Tenn. (Vanderbilt U. 1951)
Peppercorn, Bert Leonard, Cleveland, Ohio (Ohio State U. 1947)

Peres, Charles Edmond, Jr., New Orleans, La. (La. State 1950)
Perkins, Rex Beach, Winston-Salem, N. C. (Duke U. 1944)
Perry, Henry David, Jr., Miami (U. of Md. 1951)
Perry, Richard Eugene, Gainesville (Tulane U. 1951)
Philpott, William Howard, Takoma Park, Md. (Col. of Med. Evangelists 1950)
Pickering, James Aaron, West Palm Beach (Tufts Med. School 1942)
Pierson, Clarence Alexander, Pender, Neb. (Northwestern U. 1942)
Plant, Reuben Jackson, Jr., St. Augustine (Tulane U. 1949)
Pope, William Nelson, Augusta, Ga. (Med. Col. of S. C. 1940)
Porter, Fred Francis, Daytona Beach (St. Louis U. 1951)
Praytor, Hugh Bazelleel, Jr., Trussville, Ala. (Med Col. of Ala. 1946)
Price, Robert Neil, Lakeland (U. of Tenn. 1948)
Priestley, Joseph Ogden, Miami (U. of Tenn. 1950)
Puglisi, Anthony Joseph, Tampa (Loyola U. 1948)
Quilligan, Edward James, Columbus, Ohio (Ohio State U. 1951)
Raper, George Thomas, Freelandville, Ind. (Temple U. 1945)
Rapfogel, Irving, Beechhurst, N. Y. (N. Y. Homeopathic Med. Col. 1934)
Rasmussen-Taxdal, Henry Ernest, St. Petersburg (U. of Cinn. 1950)
Ratchford, Lawrence Ambrose, Clearwater (St. Louis U. 1951)
Register, Samuel Tilden, Tallahassee (Wake Forest Col. 1950)
Rivers, Walker Prioleau, Jr., Augusta, Ga. (Harvard U. 1946)
Robinson, James Earnest, Jr., St. Louis, Mo. (Wash. U. 1944)
Rogers, Lee, Jr., New Albany, Miss. (U. of Pa. 1942)
Rollins, Luther C., Jr., Canton, N. C. (Emory U. 1951)
Romberger, Floyd Troutman, Jr., Indianapolis, Ind. (Indiana U. 1937)
Rosner, Ben, Staten Island, N. Y. (U. of Rochester 1944)
Ross, Maurice Eugene, Tampa (Marquette U. 1930)
Saxon, Roy Fulward, Jr., Rochester, Minn. (U. of Tenn. 1945)
Schafer, Walter Louis, Wichita, Kan. (Ohio State U. 1937)
Schildecker, William Wightman, Daytona Beach (U. of Pittsburgh 1943)
Scott, Murray Winfield, Jr., Canton, Ohio (Harvard U. 1944)
Scott, Roger D., Miami (U. of Md. 1951)
Scott, Thomas Fletcher, Jr., Miami (U. of Tenn. 1950)
Seltzer, Bernard Benjamin, Daytona Beach (U. of Toronto 1938)
Seymour, Charles Floyd, Durham, N. C. (Duke U. 1949)
Shashy, Paul Moses, Ocala (U. of Ala. 1949)
Sheehy, Paul Lawrence, (Col.) Tampa (Meharry Med. Col. 1950)
Shulack, Norman R., Brooklyn, N. Y. (U. and Bellevue Hosp. Med. Col. 1930)
Sloane, David, Lake City (Columbia U. 1925)
Smith, Carl Marquis, Sedan, Kan. (U. of Kan. 1936)
Smith, James William, Jr., Manchester, Ga. (Med. Col. of Ga. 1951)
Snodgrass, Harold William, Miami (Med. Col. of Va. 1943)
Snyder, Kenneth Earl, Coral Gables (Albany Med. Col. 1946)
Spoto, Peter John, Tampa (Tulane U. 1951)
Stephens, Wade Naisbitt, Palatka (Geo. Wash. U. 1947)
Stewart, Harry Lawrence, Jr., Detroit, Mich. (Jefferson Med. Col. 1934)
Stiles, William Joseph, Miami (U. of Cinn. 1950)
St. John, Joseph Harold, Jacksonville (Duke U. 1945)
Stone, Melvin Maurice, Flushing, N. Y. (New York U. 1940)
Stone, Samuel Montague, Miami Beach (Middlesex Col. 1934)
Stoner, Edward William, Vicksburg, Miss. (Col. of P. & S. Boston 1945)
Struhl, Theodore Roosevelt, Brooklyn, N. Y. (New York Med. Col. 1942)
Sutherland, William Gwinner, Miami (U. of Tenn. 1950)
Thompson, John Daniel, Columbus, Ga. (Emory U. 1951)
Trapp, Carl Edward, Newton Centre, Mass. (Boston U. 1932)
Tripp, William Henry, Monticello (Emory U. 1951)
Tucker, William Cox, Birmingham, Ala. (Long Island Col. 1942)
Tunstill, James Wright, Miami (U. of Texas 1948)
Vaughan, Davis Hager, Clearwater (U. of Louisville 1945)
Venters, Homer Drae, Jr., Tampa (Emory U. 1951)
Vincenti, Fred Anthony, Blue Island, Ill. (Loyola U. 1933)
VonLehe, August Charles, Walterboro, S. C. (Med. Col. State of S. C. 1950)
Wallace, Thomas Hendrix, Sarasota (Tulane U. 1944)
Walton, Thomas Peyton, III, Tampa (Tulane U. 1950)
Weiss, Charles, Miami Beach (New York U. 1915)
Welch, William B., Miami Shores (Northwestern U. 1949)
Wigderson, Charles Bernard, New York, N. Y. (Geo. Wash. U. 1930)
Wilhelm, Richard James, Jacksonville (U. of Tenn. 1950)
Wilkes, Samuel Marion, Jr., Greenville, S. C. (U. of Penn. 1938)
Williamson, Roston Meldrim, Homestead (Med. Col. of Ga. 1951)
Wright, Victor Hugo, (Col.) Ocala (Meharry Med. Col. 1950)
Wrubel, Norman Norton, Ft. Lauderdale (Long Island Col. 1946)
Yates, G. Robert, Miami (Loyola U. 1950)
Young, Elizabeth Brown, Lake City (U. of So. Calif. 1946)
Zbar, Marcus Jacobs, Tampa (Vanderbilt U. 1951)
Zick, Luther Herman, Tampa (U. of Mich. 1943)
Zucker, Isadore, Newark, N. J. (U. of Mich. 1938)

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Artola, Robert V., West Palm Beach
Bierley, Harry E., West Palm Beach
Drexel, Adolph E., Miami
Edwards, Robert V., South Miami
Epstein, Edwin, Sanford
Esplin, Bruce M., Miami
Gage, George R., Miami
Groom, Joseph J., Miami
Jacobson, Milton B., Miami
Jarrett, Paul S., Miami
McGee, W. Ambrose, West Palm Beach
Proctor, William H., West Palm Beach
Rosenblum, Robt. R., Miami
Thompson, Rollin D., Lantana
Whitehead, Thomas, Palm Beach

YOUR BLUE SHIELD

New Non-Group Plan For Blue Cross-Blue Shield

A new plan for non-group, or individual, enrolment in the Blue Cross and Blue Shield Plans for hospital, medical and surgical care became effective last month. Under the new plan for enrolment, Blue Cross and Blue Shield may be obtained at any time during the year in all Florida counties without joining through a group. This type of enrolment was previously offered only in certain counties during set enrolment periods.

The new non-group plan is in line with the aims of these two non-profit, voluntary health organizations to offer the low cost advantages of Blue Cross and Blue Shield to as many people as possible. This type of membership is offered to residents of Florida who are under 65 years of age and in good health, and who are not eligible to join through a group. No physical examination is required. However, it is necessary for applicants to complete a health questionnaire. Non-group members are billed directly by the Plan and pay subscription charges by mail every three months.

By this time Blue Shield participating physicians should have received a small supply of application forms and descriptive literature on the new non-group plan, and a larger supply of inquiry forms designed to be given to patients to return to the Plan for complete information. Additional supplies of these forms and literature will be sent to you upon request, or you may make arrangements to receive a monthly supply by merely notifying the Blue Cross-Blue Shield Plans at 532 Riverside Avenue, Jacksonville, of the quantities you desire.

Tell all of your patients about non-profit Blue Cross and Blue Shield which may now be had either through group or non-group enrolment.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Webster Merritt of Jacksonville announce the birth of a son, Edward Ashton, on Sept. 18, 1951.

Dr. and Mrs. Leon S. Eisenman of Okeechobee announce the birth of a daughter, Esther Leah, on Sept. 20, 1951.

Dr. and Mrs. Joel Fleet of Jacksonville announce the birth of a daughter, Adele, on Sept. 23, 1951.

Marriages

Dr. James H. Mendel, Jr., and Miss Sally Anne Allan, both of Miami, were married on Aug. 31, 1951.

Deaths — Members

Lowry, James B., Lakeland ..... July 22, 1951
Moore, Homer J., Miami ..... Sept. 28, 1951

Deaths — Other Doctors

Smith, John F., Arcadia, Calif. ..... July 22, 1937
Sapp, E. Franklin, Albany, Ga. ..... Feb. 11, 1942
Myers, William A., Lincoln, Neb. ..... Mar. 1, 1943
Myers, Nicholas P., Address Unknown ..... Mar. 30, 1945
Wilson, Burrel C., Clarkson, Ky. ..... Feb. 22, 1946
Norris, Johnnie A., Jr., Birmingham, Ala. ..... April 27, 1946
McCants, Clyde H., Winston-Salem, N. C. ..... Aug. 24, 1946
Spitz, Eugene A., Chicago, Ill. ..... Dec. 28, 1946
McCaslan, Wm. H., Union Springs, Ala. ..... Sept., 1947
Hughes, Talbert W., St. Louis, Mo. ..... Apr. 12, 1950
Ward, Edwin St. John, Penney Farms ..... July 31, 1951
Nast, Alfred G., Los Angeles, Calif. ..... Aug. 11, 1951
Markley, Joseph A., Clarksburg, W. Va. ..... Aug. 13, 1951
Payne, James W., Monticello, Ga. ..... Recently

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

WANTED: Physician, Florida license. General practitioner with tendency toward internal medicine to associate with internist. City 100,000. Salary for first year. Percentage if satisfactory after first year. State salary expected, etc. Write 69-55, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: Well established E.E.N.T. practice in central Florida. Resort and college town. Year-round business. Excellent opportunity. Will leave records and equipment. Florida license necessary. Write 69-56, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: X-ray equipment and practice. North Florida city. Retiring for health reasons. Excellent location serving large territory. Nearest competition fifty miles. Will sacrifice. White P. O. Box 667, Lake City, Fla.

A. M. A. Clinical Session
December 4-7, 1951
Los Angeles

A. M. A. Public Relations Conference
December 2-3, 1951
Los Angeles

STATE NEWS ITEMS

Dr. David R. Murphey, Jr., of Tampa, president of the Florida Medical Association, was principal speaker at the September 11 meeting of the DeSoto-Hardee-Highlands-Glades Medical Society at Zolfo Springs. Dr. Murphey outlined Association activities emphasizing the two additions to its public relations program — Fair Exhibit and Rural Educational Program. Dr. Eugene B. Maxwell, also of Tampa, chairman of the Association's public relations committee, appeared on the program with Dr. Murphey. Accompanying the speakers was Mr. Tom Jarvis of Jacksonville, Assistant Supervisor, F. M. A. Bureau of Public Relations. Dr. Hubert W. Coleman, of Avon Park, president of the Society, presided. Some 25 members and guests were present for the dinner meeting.

Dr. Joseph R. West of Palm Beach recently addressed the first fall meetnig of District 9, Florida State Nurses Association on the subject, "The Responsibility of a Nurse to Her Community During Time of Disaster."

Dr. John T. Stage of Jacksonville was the principal speaker at the commencement exercises of the Riverside Hospital class of graduating nurses. Also included on the program were Drs. Turner Z. Cason and Donald P. White, Jr.

Dr. George F. Hieber of St. Petersburg recently lectured to a group of registered nurses on skin diseases and recent advances in treatment of allergies.

Dr. Reuben B. Chrisman, Jr., of Miami was one of the guest speakers at the centennial meeting of the Kentucky State Medical Association in Louisville on October 2. Dr. Chrisman's subject was "Doctors Are Citizens, Too."

Dr. Marlin C. Moore of Jacksonville has returned to his practice following a trip through the eastern United States into New England where he visited various hospitals, clinics and other medical organizations.

Dr. Eugene G. Peek, Sr., of Ocala, and Dr. Francis T. Holland, of Tallahassee, are the first speakers to fill engagements in connection with the Rural Educational Program. Dr. Peek spoke to a meeting of all white Florida Agricultural Extension Service personnel on the University of Florida campus October 10, and Dr. Holland filled a similar engagement before a Negro county and home demonstration agents' meeting October 18 on the campus of Florida A. & M. College, Tallahassee.

Dr. Peek is chairman of the Committee on Legislation and Public Policy and Dr. Holland is a member of the F.M.A. Committee on Public Relations.

Dr. Samuel M. Day of Jacksonville, secretary-treasurer of the Association, has been elected a member of the Board of Trustees of the Jacksonville Arts Club, Inc.

Dr. Edith M. Corlew of Tampa, addressed a September meeting of the Hillsborough Federation of Women's Clubs on the subject, "Attitude Between Parents and Children that Contributes Towards Delinquency in Their Children."

Dr. Herbert L. Bryans of Pensacola, president of the State Board of Health, addressed the opening session of the National Association of Sanitarians Convention at Miami Beach on August 21.

Dr. John O. Brown, Palmetto, was signally honored by friends and former patients on his 82nd birthday September 10. An estimated 750 persons including Dr. Brown's five surviving children and eight grandchildren attended the celebration in his honor.

A native of Alabama, Dr. Brown began practicticing in Palmetto in 1894. He received his Doctor of Medicine degree from the Kentucky School of Medicine in 1890. He retired from active practice several years ago, but several of his patients still go to his home for consultation and advice.

Dr. Eugene B. Maxwell of Tampa, chairman of the F. M. A. Committee on Public Relations, and Mr. Tom Jarvis, Assistant Supervisor of the Association's Bureau of Public Relations, were guest speakers at the meeting of the Florida Public Health Association in the Casa Blanca Hotel on Miami Beach October 5.

Dr. Thomas S. Griggs of Miami will be away from his practice approximately one year while taking a postgraduate course in Anesthesiology in New Orleans.

Dr. Albert V. Hardy of Jacksonville recently addressed a local branch of the American Association of University Women on his experiences in Korea as a member of the dysentery research mission.

Dr. Harrison G. Palmer of St. Petersburg recently returned from an extended trip throughout the eastern United States and Canada. During his tour, Dr. Palmer visited numerous hospitals and clinics.

Dr. Cornelius A. Bird of Jacksonville was the guest speaker at the August meeting of the Columbia County Medical Society.

Dr. Luther L. Pararo, Jr., of Tallahassee is temporarily absent from his practice while doing advance work in surgery at the Baroness Erlanger Hospital in Chattanooga.

Dr. Sherman B. Forbes of Tampa was the principal speaker over radio station WDAE on Sunday, September 16, in a program dealing with sight conservation. Also participating on the program which was sponsored by the Florida Council for the Blind, was Dr. Frank V. Chappell of Tampa.

Dr. Philipp R. Rezek of Miami has returned to his practice following a trip to London, England, where he presented a paper before the International Congress of Clinical Pathologists.

Drs. Sullivan G. Bedell, Hugh A. Carithers, J. K. David, Jr., F. Gordon King, Robert B. Ragland and G. Dekle Taylor, all of Jacksonville, participated in a local all day program on speech correction September 5.

COMPONENT SOCIETY NOTES

Columbia

The Columbia County Medical Society held its regular monthly meeting in August in Lake City. Guest speaker was Dr. Cornelius A. Bird of Jacksonville who spoke on "Herniated Intervertebral Discs."

Dade

At the regular monthly meeting of the Dade County Medical Association on October 2, a symposium on car pulmonale with lantern slides was presented by Drs. Morris M. Dick, George Baum, Jack Reiss and Sidney Fox.

DeSoto-Hardee-Highlands-Glades

The regular monthly meeting of the DeSoto-Hardee-Highlands-Glades Medical Society was held on September 11 at Zolfo Springs. Guest speaker was Dr. David R. Murphey, Jr., president of the Florida Medical Association. Also in attendance were Dr. Eugene B. Maxwell, Chairman of the Association's Committee on Public Relations, and Mr. Tom Jarvis, Assistant Supervisor, F. M. A. Bureau of Public Relations.

Duval

The regular monthly meeting of the Duval County Medical Society was held on October 2. Members were privileged to hear a talk by Dr. Albert V. Hardy, Director of Laboratories in the Florida State Board of Health. Dr. Hardy's topic was "Problems in the Medical Care of Prisoners of War in Korea."

Hillsborough

At the October meeting of the Hillsborough County Medical Association, Dr. Frank Chunn spoke on "A Surgical Treatment for Aneurisms." His talk was illustrated with kodachrome slides.

Marion

All members of the Marion County Medical Society have paid their state dues for 1951.

Pinellas

The annual meeting of the Pinellas County Medical Society was held on October 1 for the consideration of yearly business.

Errata

Dr. Joseph M. Bistowish of Tallahassee has called to the attention of The Journal that Dr. Raney A. Oven of Tallahassee presented the paper on scurvy before the last quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. Dr. Bistowish had erroneously been given credit in the October Journal for presenting this paper.

OBITUARIES

Herbert Walter Counts

Dr. Herbert Walter Counts of Jacksonville died at a local hospital on July 4, 1951 following an illness of several months. He was 67 years of age. Interment was in Ocala.

A native Floridian, Dr. Counts was born in Ocala in 1884. He received his early education in that city and then attended Vanderbilt University. In 1911, he was graduated from the School of Medicine of that institution. For a time he practiced in Dunnellon, but since 1916 had practiced in Jacksonville. He was a Mason and a member of the Methodist Church.

Dr. Counts was a life member of the Duval County Medical Society, and a life member of the Florida Medical Association, with which he had been affiliated for forty years. He also held membership in the American Medical Association.

Surviving are three sisters; Miss Edna Counts of Jacksonville, Mrs. W. H. Fuller of Neptune Beach, and Mrs. W. M. Munroe of Gainesville; and one brother, Junious Counts of Ocala.

Selmer Pareli Smiseth

Dr. Selmer Pareli Smiseth of St. Petersburg died in a hospital in Traverse City, Mich., on July 21, 1951, following a heart attack. He was 56 years of age.

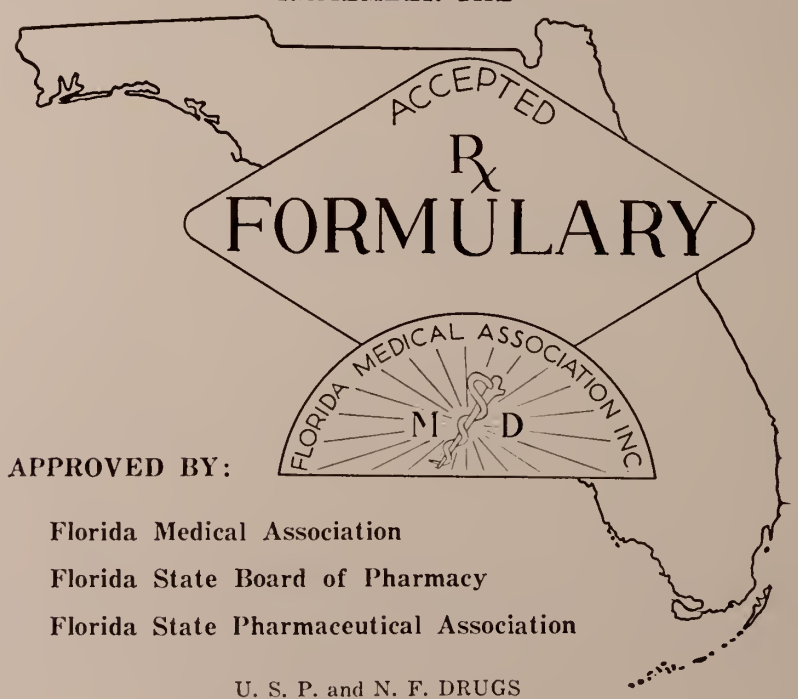
A native of Michigan, Dr. Smiseth was born at Suttons Bay on May 30, 1895. He received his medical training at the University of Michigan Medical School and was graduated in 1924. Licensed to practice medicine in Florida in 1935, he engaged in general practice at Gulfport nine months of the year and during the summer months practiced in Suttons Bay, where he had practiced before coming to Florida.

In 1942, Dr. Smiseth moved his office to St. Petersburg and continued in general practice there from fall through spring. He remained longer through the demanding war years and then resumed his summer practice in Michigan, where he delighted to sail the Great Lakes around the Michigan peninsula.

Dr. Smiseth was a member of the Pinellas County Medical Society, the Florida Medical Association and the American Medical Association.

Surviving are the widow, Mrs. Alberta Smiseth; one son, Frederick Smiseth; and three daughters, Mail and Alberta Smiseth, and Mrs. Donald Pearson of Nashville, Tenn.

REMEMBER THE



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FOR REGULAR PRESCRIBING

An Advertisement of G. D. Searle & Co.

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement of Actions and Uses and of Dosage for publication in connection with a description of Banthīne Bromide for inclusion in New and Nonofficial Remedies)

Methantheline Bromide.—*Banthīne® Bromide (Searle)*

β-diethylmethylaminoethyl 9-xanthenecarboxylate bromide

Actions and Uses.—Methantheline bromide, a parasympatholytic agent, produces both the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

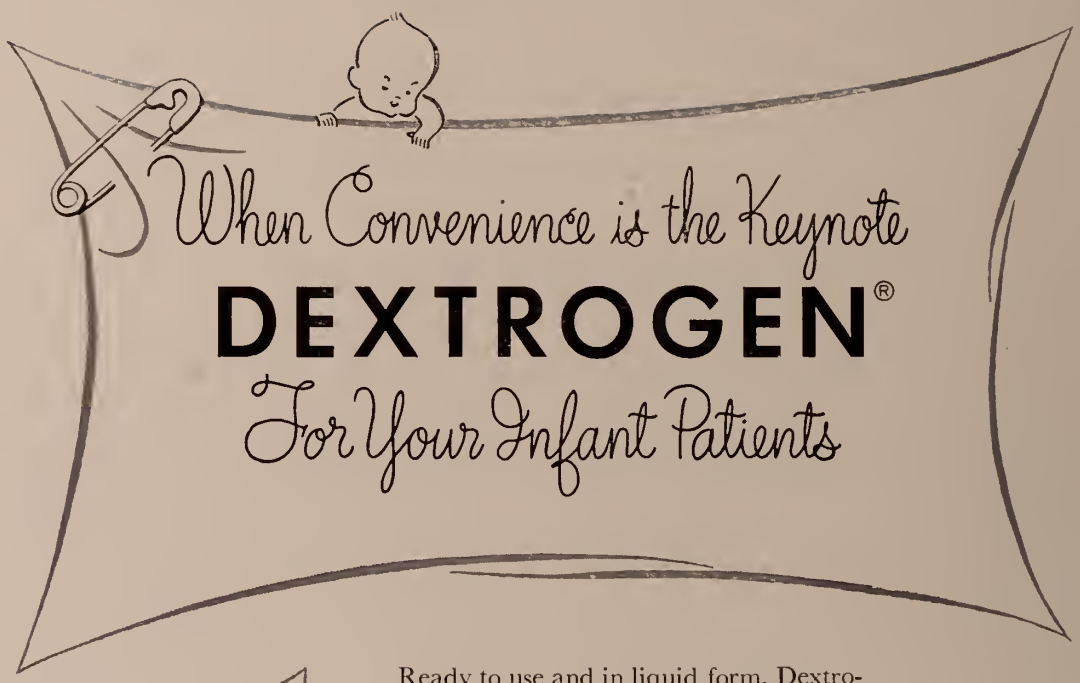
Clinical studies indicate that the drug effectively inhibits motility of the gastrointestinal and genitourinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degree may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

Dosage.—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial adult dose, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

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Tablets Banthīne Bromide: 50 mg.
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Ready to use and in liquid form, Dextrogen is a concentrated infant formula, made from whole milk modified with dextrins, maltose, and dextrose. In addition, it is fortified with iron to compensate for the deficiency of this mineral in milk. Diluted with 1½ parts of boiled water,* it yields a mixture containing proteins, fats and carbohydrates in proportions eminently suited to infant feeding. In this dilution it supplies 20 calories per ounce.

Then Feed

The higher protein content of normally diluted Dextrogen—2.2% instead of 1.5% as found in mother's milk—satisfies every known protein need of the rapidly growing infant. Its lower fat content makes for better tolerability and improved digestibility.

Dextrogen serves well whenever artificial feeding is indicated, and is particularly valuable when convenience in formula preparation is desirable.

*Applicable third week and thereafter; 1:3 for first week, 1:2 for second week.

ACCEPTED Council on Foods and Nutrition American Medical Association

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All the mother need do is pour the contents of the Dextrogen can into a properly cleaned quart milk bottle, and fill with previously boiled water. Makes 32 oz. of formula, ready to feed.*

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BOOKS RECEIVED

FROM A DOCTOR'S HEART. By Eugene F. Snyder, M.D. Pp. 251. Price, $3.75. New York, Philosophical Library, 1951.

This personal account of pain, courage, despair and hope, from the pen of a physician who wishes to help the healthy to keep well and to assist the sick to regain their health, is written "FROM THE HEART, TO THE HEART, AND ABOUT THE HEART" in the widest sense of the word. After fleeing bloody European revolutions and finally finding peace in the United States, the author narrowly escaped death from a coronary thrombosis. In this scientifically and spiritually illuminating book, he answers many practical questions pertaining to the physical and mental health, and touches on the national, racial and political problems of the day.

The book is written in the form of a discussion between the author, his wife (also a physician), and their teen-age son. Supplementing the witty and wise discussions are many humorous stories and caricatures, and the autobiographic material compares life in Russia, Middle Europe and the United States. Antitotalitarian, the book seeks to promote good interfaith and interracial relationships. It glorifies the general practitioner as the backbone of the medical profession, and the writing is highlighted by a eulogy of America and the ideals of democracy.

Dr. Paul Dudley White, in the foreword, commented: "This book, written by a physician who has suffered many things, is a token of the stoutness and resilience of the human spirit. . . . The lesson strongly pointed out by Dr. Snyder is two-fold; first, that of bettering human relationships throughout the world today, and second, that of a search for all possible clues and prophylactic measures against the health hazard of coronary heart disease. I can heartily recommend this book for perusal by those who are interested in both of these problems; most of mankind today should be so interested."

A PRESS CONFERENCE ON THE EXCEPTIONAL CHILD. Proceedings of a Special Conference between Members of the Press and a Panel of Authorities Under the Auspices of the Child Research Clinic of The Woods Schools, a Private School for Exceptional Children, Langhorne, Pennsylvania on Tuesday, March 20, 1951.

The proceedings of a press conference, held last spring in New York to review the latest scientific developments in the treatment of mental and emotional deviation in children, has just been published by The Woods Schools, Langhorne, Penn. This pamphlet, 30 pages in length, is in two parts. The first part is a roundup review by experts of the newest significant developments in psychology, psychiatry, pediatrics, education and institutional care. The second part is a question-and-answer discussion in which the press participated in "Meet the Press," TV-style.

The purpose of the conference was "to bring up to date, not only for parents, but for the general public, what is known and accepted about mental retardation in children, and what facilities and techniques are available for its treatment and control." Copies of the pamphlet may be obtained without charge by writing to the Child Research Clinic of The Woods Schools, Langhorne, Penn.

Advertisement



From where I sit
by Joe Marsh

Guess They Felt Pretty "Sheepish"

My wife and I went to Central City for the football game and it was a top-notcher. But I began to wonder if it was worth the trouble when we got in a traffic jam coming home.

Traffic makes me mighty impatient. When I came to a side road that seemed to point towards the main highway, I turned onto it. This road bumps along for maybe a mile or two, then fetches up short by the railroad spur—a dead end.

So, I turned around and darned if there weren't twenty cars behind me! One driver had followed—figuring I knew about a short cut—then a whole string of them swung after him, just like sheep.

From where I sit, it doesn't pay to follow just because someone makes a "new turn." Choosing a road, a political party, or the way to practice a profession should be up to the individual. The same goes for your choice of beverage—I like a glass of beer—but, most of all, I like the freedom of making up my mind about it!

Joe Marsh

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Relationship of Stress to Autonomic Lability

Studies in psychosomatics have shown that functional disorders often are a result of the patient's inability to adjust to emotionally stressful situations (stressor factors).

Nervous tension and chronic anxiety, discharged through a labile Autonomic Nervous System, can cause somatic disturbance. [1,2] Such states may involve any one of the organ systems or several at one time. [1,3] The outline below is designed to relate gastrointestinal and cardiovascular symptomatology to the exaggerated response of the autonomic nervous system.

	Physiologic Effects of Autonomic Discharge	
	Sympathetic	Parasympathetic
Gastro-intestinal System	Hypomotility Intestinal Atony Hyposecretion Reduced salivation	Hypermotility Gastrointestinal spasm Hypersecretion
Cardio-vascular System	Rapid heart rate Peripheral vaso-constriction	Slow heart rate Vasodilatation
Functional Manifesta-tions	Palpitation Tachycardia Elevated blood pressure Dry mouth and throat	Heartburn Nausea-vomiting Low blood pressure Colonic spasm

The data here tabulated is from references [3,4,5,6,7] given below.

When the clinical picture is suggestive of functional disorder, the diagnosis is supported by the presence of the following indications of autonomic lability:

Variable Blood Pressure
Body Temperature Variations
Changing pulse rate
Deviations in B. M. R.
Exaggerated Cold Pressure Reflex
Oculo-Cardiac Reflex Abnormalities
Glucose Tolerance Alterations

Therapy in these cases is directed toward: 1) relieving the somatic disturbance to prepare the patient for psychotherapy*; 2) guidance in making adjustment to stressful situations and correction of unhealthy attitudes.

*Drug treatment using adrenergic and cholinergic blocking agents in conjunction with sedatives. [8,9,10.]

1. Ebaugh, F.: Postgrad. Med. *4:* 208, 1948. 2. Wilbur, D.: J.A.M.A. *141:* 1199, 1949. 3. Williams, E. and Carmichael, C.: J. Nat'l. Med. Assoc. *42:* 32, 1950. 4. Goodman, L. and Gilman, A.: The Pharmacological Basis of Therapeutics, The Macmillan Co., 1941. 5. Katz, L. et al: Ann. Int. Med. *27:* 261, 1947. 6. Weiss, E. et al: Am. J. Psychiat. *107:* 264, 1950. 7. Alvarez, W.: Chicago Med. Soc. Bulletin, 581, 1950. 8. Rakoff, A.: A Course in Practical Therapeutics, Williams and Wilkins, 1948. 9. Karnosh, L. and Zucker, E.: A Handbook of Psychiatry. C. V. Mosby Co., 1945. 10. Harris, L.: Canad. M.A.J. *58:* 251, 1948.

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Time for Inventory

When our annual report showed that out of 36 county medical societies we only had 19 auxiliaries we felt we had far to go before we could proudly announce 100 per cent organization of Florida Auxiliaries. This is our goal and it is important that we reach it. So a study of the remaining 17 unorganized areas was in order. This study revealed an interesting and cheerful fact. Out of all 17 counties there are only 167 members of the Association whose wives we have to reach. In many counties the membership in the county medical society is so small we can cover the area with a few members-at-large.

One of the reasons we have made little progress in those areas is that when several counties are included in one society the members are spread out and their wives feel too separated and too few to justify an organization. This is an attitude we would like to correct. We urge the wives of Association members, however isolated they may be, to accept membership-at-large because we need a source through which material concerning the medical profession can be funnelled into each community. For the community may have organizations actively engaged in fostering propaganda detrimental to American medicine, and without educational material on hand to combat this trend the public is hampered in its judgment.

In view of the ideologies which are being endorsed throughout the country by certain lay organizations, it is expedient that we identify ourselves with organizations which are formed to uphold our principles and protect our interests.

It is our sincere hope that the 17 doctors who are presidents of county societies which have no auxiliaries will assist us in creating affiliation in their areas so that by the end of the year we can announce that the 167 members' wives who do not now belong will join forces with the rest of the state to help us hold the ground we have gained.

If a doctor's wife is eligible for membership in this educational organization which is actively assisting her husband, yet chooses not to belong she is not ready for organization . . . it is time for inventory.

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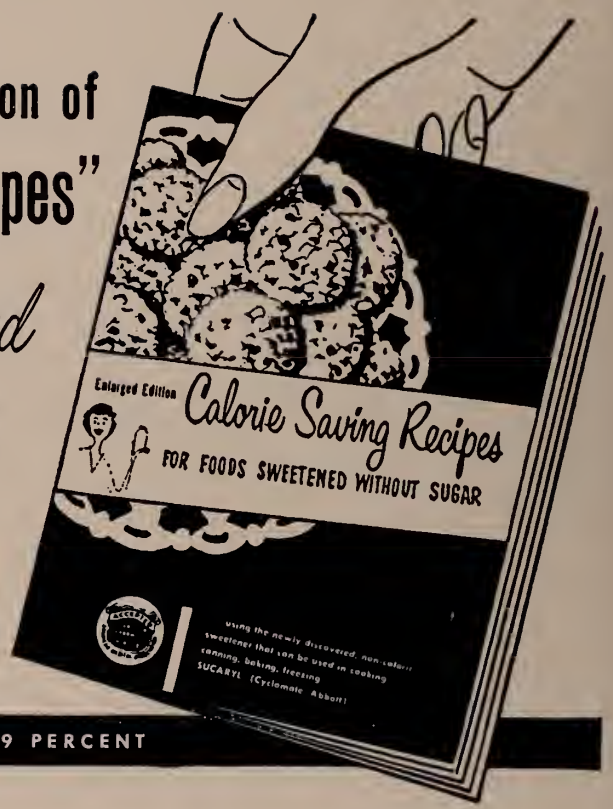


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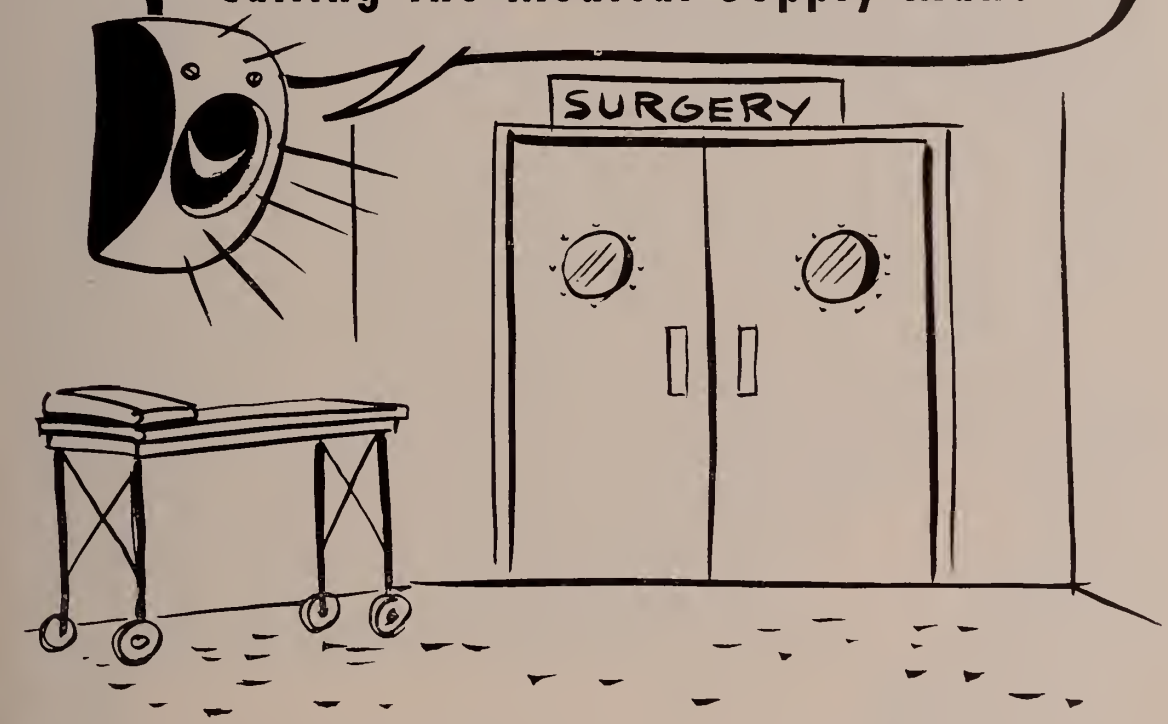


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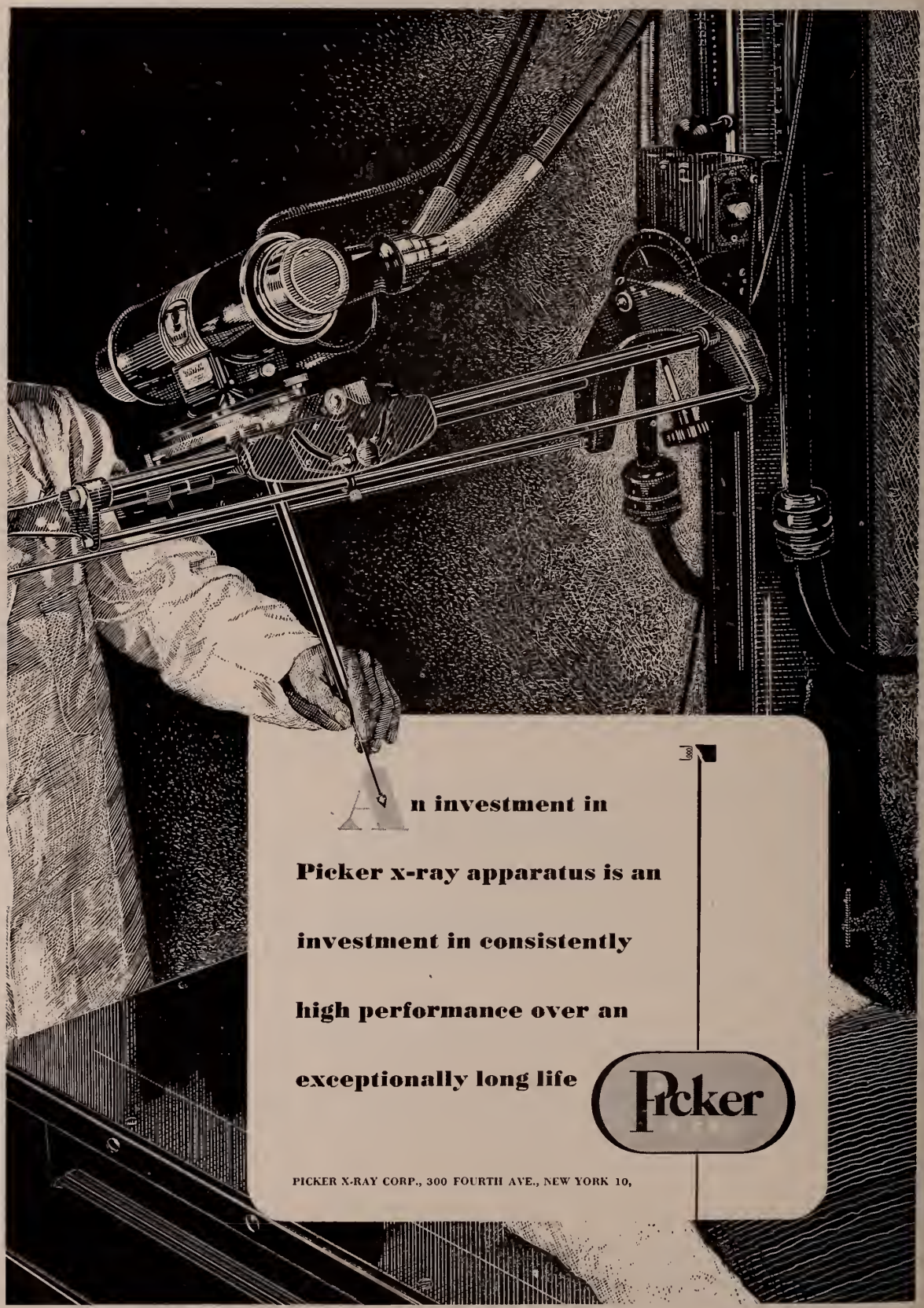
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1. Towse, R. C., Berberian, D. A., and Dennis, E. W.: *New York State Jour. Med.*, 50:2035, Sept., 1950.
2. Berberian, D. A., Dennis, E. W., and Pipkin, C. A.: *Am. Jour. Trop. Med.*, 30:613, Sept., 1950.

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1. Cannon, P. R.: Recent Advances in Nutrition with Particular Reference to Protein Metabolism, Lawrence, Kansas, University of Kansas Press, 1950, pp. 56-60.

2. Rose, W. C.: The Nutritive Role of the Amino Acids, The Science of Nutrition, New York, The Nutrition Foundation, 1946.

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*Clein, N. W.: Cow's Milk Allergy in Infants, *Annals of Allergy*, March-April, 1951.

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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
ida Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '52
ida Medical Districts	William C. Roberts, Panama City	Council Chairman	
-Northwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	
-Northeast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	
-Southwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	
-Southeast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	
ida Specialty Societies			
lemy of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	Hollywood, Apr. 27, '52
gy Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	" "
sthesiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
pter, Am. Coll. Chest Phys.	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
n. and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
th Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
t Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	" "
strial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	" "
ology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
and Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
thal & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	" "
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atric Association, State	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Laudardale	" "
tologic Society	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	Orlando, Nov. 10-11, '51
ological Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	Hollywood, Apr. 27, '52
ogical Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
da—	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
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spital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando, Dec. 3-4, '51
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armaceutical Association, State	Mr. Euless Watford, Chipley	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-21, '52
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rican Medical Association	John W. Cline, San Francisco	Geo. F. Lull, Chicago	
M.A. Clinical Session	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Los Angeles, Dec. 4-7, '51
hern Medical Association	Curtice Rosser, Dallas, Texas	Mr. C. P. Loranz, Birmingham	Dallas, Texas, Nov. 5-8, '51
ama Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19, '52
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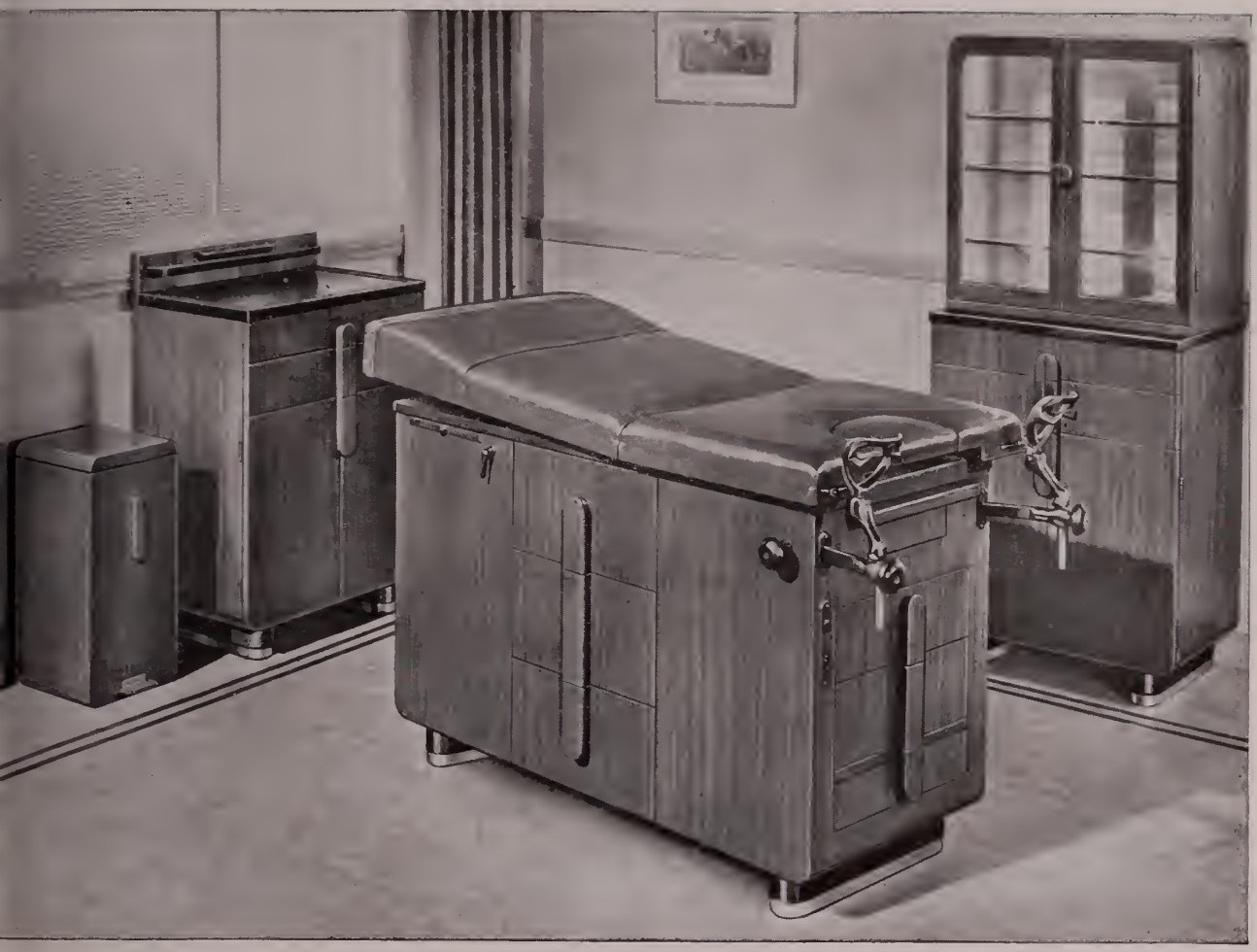
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	Escambia *Santa Rosa*	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	75	70	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	7	100%	
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	Taylor *Dixie-Lafayette*	Ralph J. Greene, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	229
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	Duval *Clay*	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	240	232	
	Marion *Levy*	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	27	100%	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	100%	
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	Manatee	Roderic O. Jones, M.D. 430 10th St., W. Bradenton	Marjorie L. Warner, M.D. 404 12th St., W. Bradenton	2nd Tuesday 8:30 P.M.	22	20	
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	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 203 Van Skike Bldg. Sarasota	2nd Tuesday 8:30 P.M.	42	41	
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Vol. XXXVIII DECEMBER, 1951 No. 6

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Richard E. Strain and Irwin Perlmutter

Cancer of the Prostate
Joseph Q. Perry and Arthur J. Butt

Disabling Conditions of the Cervical Spine
Fred H. Albee, Jr., Eugene L. Jewett and Earl J. Powers

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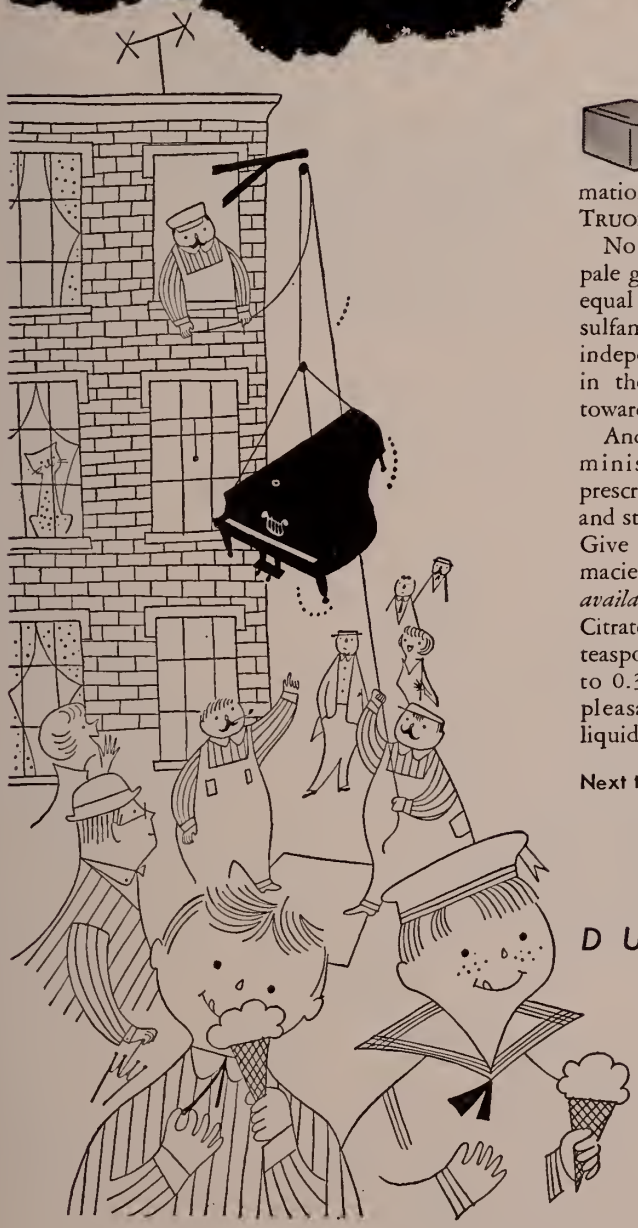
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Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

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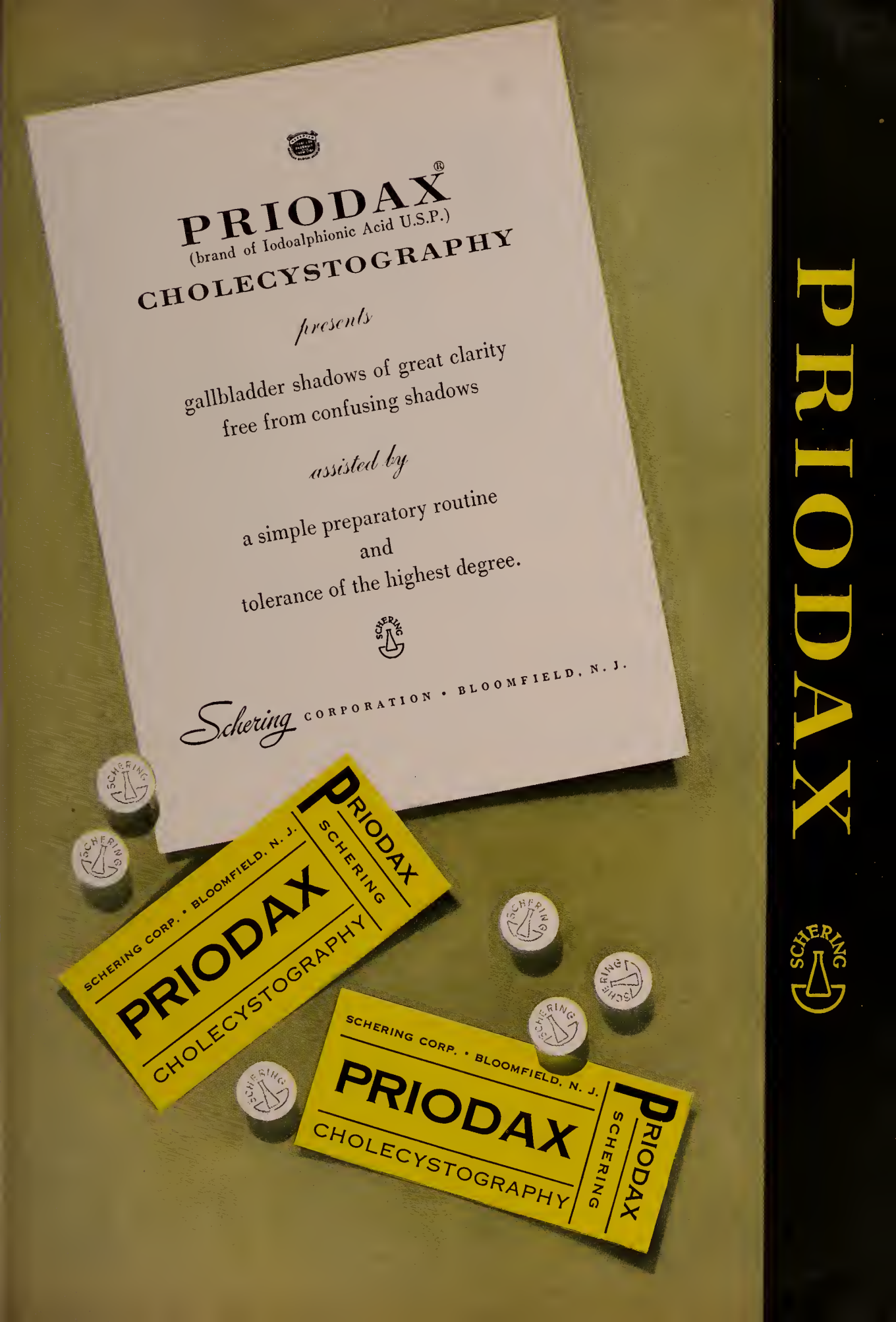


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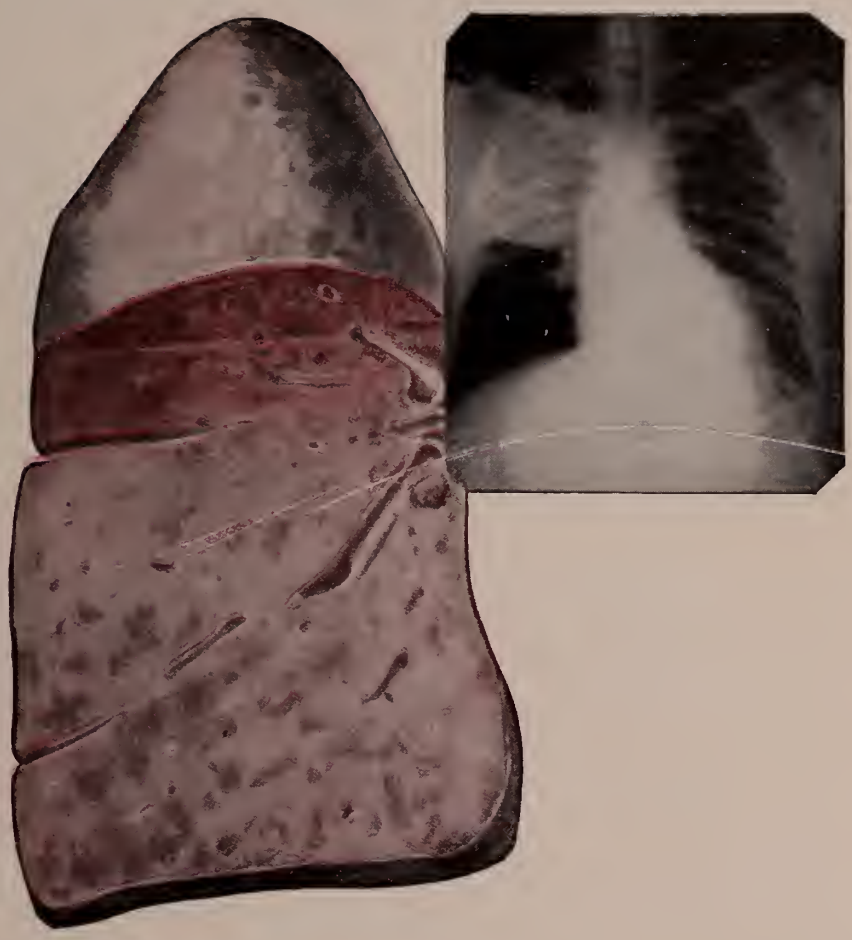
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Potterfield, T. G., and Starkweather, G. A.:
J. Philadelphia General Hosp. 2:6 (Jan.) 1951

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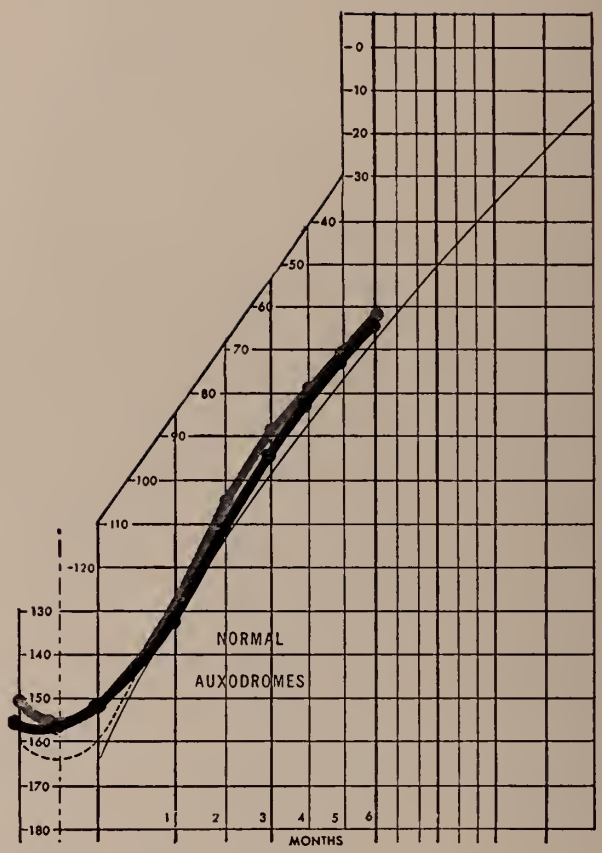
Normal schedule of development (auxodrome) plotted on Wetzel Grid.[1]

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Composite Wetzel Grid auxodrome of 60 unselected infants on S-M-A from birth to 6 months of age.

CURVE B

Growth data, recomputed on Wetzel Grid, based on "selected subjects, most of whom were favored by environment;"[2] age: from birth to 6 months.



1. Wetzel, N. C.: J. Pediat. *29*:439, 1946.
2. Jackson, R. L., and Kelly, H. G.: J. Pediat. *27*:215, 1945.

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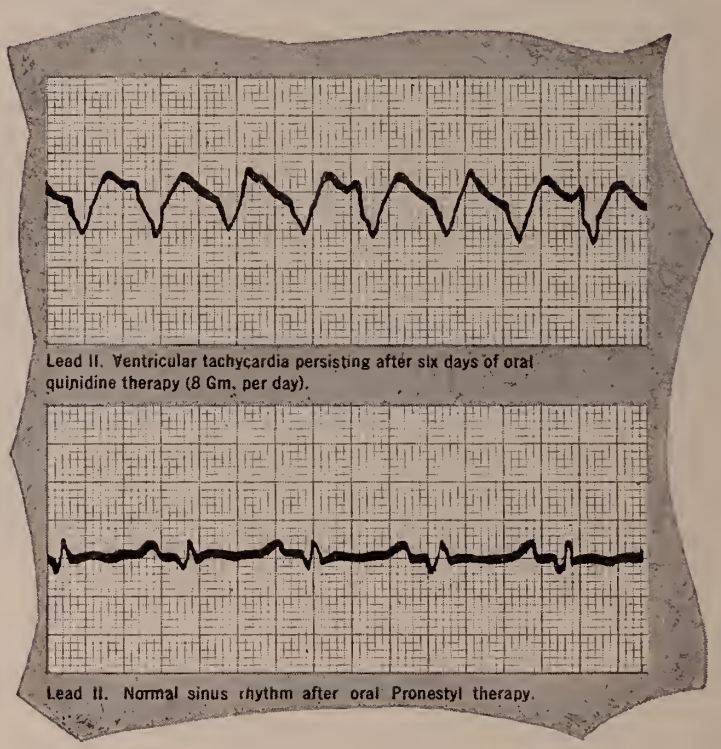
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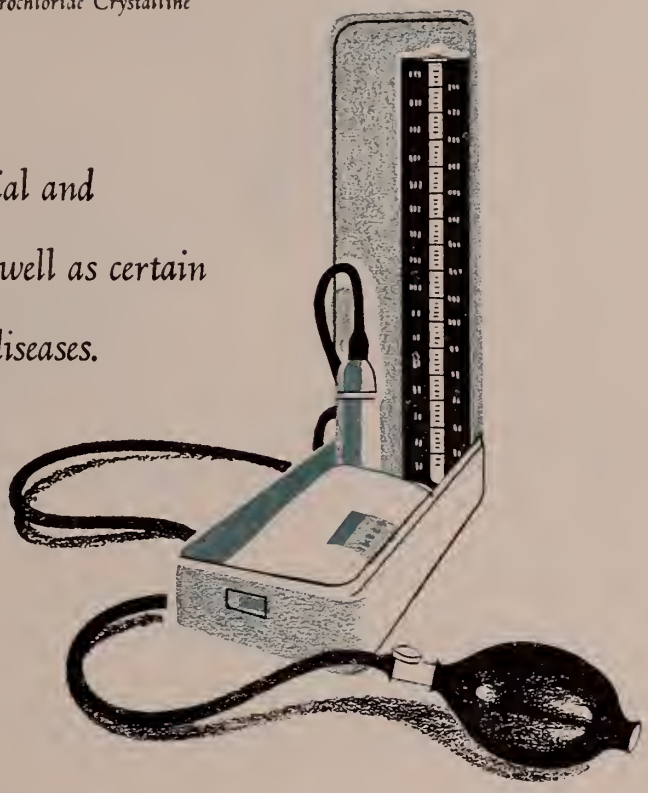
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXVIII Jacksonville, Florida, December, 1951 No. 6

Strokes: Their Diagnosis and Treatment

RICHARD E. STRAIN, M.D.
AND
IRWIN PERLMUTTER, M.D.
MIAMI

The diagnosis of a "stroke" is usually obvious to both physician and layman. The term generally means the patient has had a sudden paralysis. If the patient is unconscious and blood is found in the spinal fluid, there is no hesitancy in saying the patient has had a cerebral hemorrhage. If no blood is found in the spinal fluid, a diagnosis of cerebral thrombosis is made. This greatly simplifies matters for the physician, but, unfortunately for the patient, it has left little to look forward to in the way of actual treatment.

Different pathologic lesions, each requiring different treatment, may produce a "stroke." This fact has largely been forgotten. Many "C V A's" do not have adequate diagnostic or postmortem studies made; so the true nature of the lesion in the brain is not proved. We have thought that the "brain specialist" can add something to the treatment of these patients with so-called cerebrovascular accidents of the brain if he is permitted to see them early and uses adequate means of study.

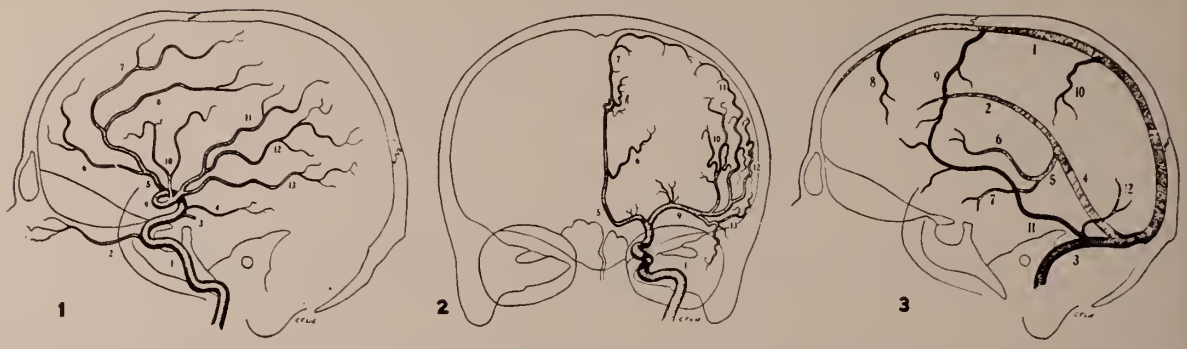
Air studies[1] accurately localize space-occupying lesions, but are of little help in vascular lesions. The method has the further disadvantage that it entails a minimum of five to seven days' hospitalization even when no surgical abnormality is found. A diagnostic procedure has been needed which would visualize the vascular channels of the brain without great discomfort or danger to the patient and would not entail a long period of hospitalization as a result of the test. Egas Moniz[2] of Portugal evolved such a test in cerebral angiography (figs. 1-3).

Percutaneous cerebral angiography with the use of 35 per cent diodrast introduced into the carotid artery by simply inserting a needle through the skin into the artery is a safe, simple and quick method of studying the vascular system of the brain.[3] It is usually carried out under local anesthesia. If no surgical lesion is present, the patient may leave the hospital the same day or the following morning. Cerebral angiography gives information concerning lesions of the brain which cannot be obtained any other way except at autopsy. It requires some specialized x-ray equipment, a little skill, and split second teamwork with x-ray technicians.

We have performed this test over 100 times during the past year without any complications or ill effects except for 2 mild cases of urticaria that responded promptly to benadryl. At the Lahey Clinic Poppen[4] has performed the test over 1,500 times without serious complications.

We wish to demonstrate that adequate diagnosis of the pathologic condition present is essential in the treatment of patients with "strokes."[5] The methods used to demonstrate the pathologic lesion present in the cases described are self explanatory. These cases are only part of a series which we have observed in which a diagnosis of "stroke or C V A" was made by one or several physicians who saw the patients, including ourselves. We are certain that without adequate diagnostic study some of them would have been mistreated as simple cerebral thrombosis when in reality some other pathologic change was the prime factor in the disability.

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 24, 1951.



Figs. 1-3. Schematic drawings of normal arteriograms and venogram obtained by injection of the internal carotid artery.

Figs. 1 and 2. Arteriograms in lateral and anteroposterior projections.

1. Internal carotid artery. 2. Ophthalmic artery. 3. Posterior communicating artery. 4. Anterior choroidal artery. 5. Anterior cerebral artery. 6. Frontopolar artery. 7. Callosomarginal artery. 8. Pericallosal artery. 9. Middle cerebral artery. 10. Ascending frontoparietal artery. 11. Posterior parietal artery. 12. Angular artery. 13. Posterior temporal artery.

Fig. 3. Venogram in lateral projection.

1. Superior sagittal sinus. 2. Inferior sagittal sinus. 3. Transverse sinus. 4. Straight sinus. 5. Great cerebral vein of Galen. 6. Internal cerebral vein. 7. Basal vein of Rosenthal. 8. Frontal ascending vein. 9. Rolandic vein of Trolard. 10. Parietal ascending vein. 11. Communicating temporal vein of Labbé. 12. Descending temporo-occipital vein. (Courtesy, List, C. F. and Hodges, F. J.: Radiology, October 1946.)

Report of Cases

Case 1. — L. H. was a 61 year old right-handed consulting engineer admitted to Doctors Hospital in April 1950. He was a known diabetic of two years' duration. In March 1949 he awoke his wife with his struggles in bed, at which time he was unconscious four hours. After study in the hospital a diagnosis of cerebral thrombosis and generalized seizures was made. In August he suffered some difficulty with his speech. In September he had a sudden onset of pain and weakness in the right arm which persisted. His speech became indistinct, and he became unable to read, write, talk or walk. Examination in April showed a blood pressure of 120 systolic and 70 diastolic. He had a right facial weakness of central type, a right-sided weakness with hyperactive right reflexes and a right Babinski sign. The fundi showed only arteriovenous nicking. A clinical diagnosis of a left frontal infiltrating lesion was made on the basis of the history of progression.

Percutaneous arteriography disclosed widening of the space between the anterior and middle cerebral arteries with a lack of vessels in the area denoting either a benign tumor or abscess (fig. 4). On the anteroposterior view (fig. 5) the anterior cerebral artery was pushed beyond the midline. Operation disclosed a large, thick-walled abscess cavity from which 80 cc. of sterile pus was removed. Following drainage by catheter the patient was able to talk, walk and read. A biopsy of the wall showed ependymoma. The patient was discharged two and one-half weeks postoperatively. He improved steadily until July 1950 when he had a generalized seizure followed by right-sided weakness despite anticonvulsant therapy. A ventriculogram disclosed a pronounced shift. The bone flap was re-elevated, and after aspiration of 70 cc. of thin, sterile pus, the entire wall of the degenerated tumor was excised. Recovery was uneventful with discharge three weeks later. He has occasional spells of confusion.

Case 2. — F. D. was a 52 year old right-handed executive admitted to Mt. Sinai Hospital in February 1950. Six weeks before, there had suddenly developed weakness of the right arm. A diagnosis of thrombosis was made by a neurologist and a neurosurgeon in a large midwestern city. Stellate blocks were done repeatedly. He was advised to rest in Florida and drove down here. On the way he suddenly became weak in the right arm and leg. He was found to be confused with slurred speech and inability to name objects. Papilledema was present. There was a right facial weakness with a right-sided paralysis and a right hemihypesthesia. The right reflexes were hyperactive with clonus and a right Babinski sign. The clinical diagnosis was an infiltrating tumor of the left parietotemporal area. A ventriculogram disclosed a left parietotemporal mass which was removed and diagnosed as "glioma." Recovery was uneventful, the patient being up on the fifth day. He remained unable to speak, and the right hemiplegia persisted. He died one year later of recurrent glioblastoma.

Case 3. — K. B. was a 60 year old ambidextrous engineer admitted to Doctors Hospital in April 1950 complaining of loss of equilibrium of two weeks' duration. Ten months before admission, there had developed sudden numbness of the right hand lasting three weeks and diagnosed as a 'mild stroke.' Examination disclosed a blood pressure of 190 systolic and 100 diastolic. There was a

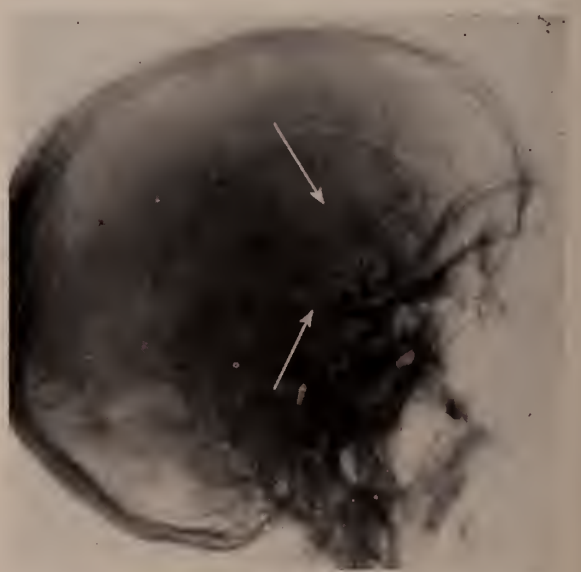


Fig. 4. — Anteroposterior view shows the anterior cerebral artery pushed beyond the midline by a mass which proved to be ependymoma at operation.

residual of a right hemiplegia with a right Babinski sign. Some finger to nose ataxia was noted on the right. The fundi were normal. A clinical diagnosis of a vascular lesion without focal signs plus a residual of a right hemiplegia was made, the etiology to by proved by tests. Roentgenograms of the chest were normal. Percutaneous arteriography disclosed some forward angulation of the anterior cerebral artery with depression of the left middle cerebral artery suggesting a space-occupying lesion in the left parietal area.

The patient's wife found the diagnosis of a tumor difficult to accept and requested consultation with a neurologist. He thought the patient had either a tumor or thrombosis and advised ventriculography. This disclosed only slight flattening of the body of the left lateral ventricle. A left temporoparietal craniotomy disclosed only normal cortex. By palpation it was felt there was a small, hard mass deep in the receptive speech area. It was concluded this could not be removed without leaving permanent speech and motor defects which the wife violently opposed; so after needling of the area, the wound was closed. The patient improved and left the hospital in three weeks under his own power. We told his wife she must expect a downhill course. He died three months later, and the brain was sent to us for studies. Three nodules of tumor were found in the brain, two in the left parietal and one in the right parietal area. The sections, after review by Dr. Webb Haymaker, were diagnosed sarcoma of the brain.

Case 4. — Mrs. F. was a 44 year old housewife admitted to Mt. Sinai Hospital in August 1950 because of sudden bitemporal headache with vomiting. She had had daily headache on waking for three years. She was said to have had a cerebral hemorrhage because bloody spinal fluid was found. Neurologic examination was normal throughout. A clinical diagnosis of subarachnoid hemorrhage from a ruptured aneurysm without focal signs was made. Bilateral percutaneous arteriography disclosed an aneurysm of the left middle cerebral artery (figs. 6 and 7). The left common carotid artery was ligated. Recovery was uneventful, and she continues well to date.

Case 5. — Mrs. A. was a 33 year old housewife admitted to Doctors Hospital in April 1951. She had had severe occipital headache for two days. Eleven years previously while in labor, she was said to have had a cerebral hemorrhage with a right hemiplegia which improved. Examination disclosed a stiff neck and the residual of a right hemiplegia. A clinical diagnosis of angioma on the basis of repeated bleeding was made. Lumbar puncture disclosed a bloody fluid. Bilateral percutaneous arteriography disclosed an angioma which was filled from the right side (figs. 8 and 9). Many such angiomas may be present on the surface as a tangle of wormlike vessels. They should be excised by clipping the arterial feeders if accessible.



Fig. 6. — Anteroposterior view disclosing angioma filled from right anterior cerebral artery.

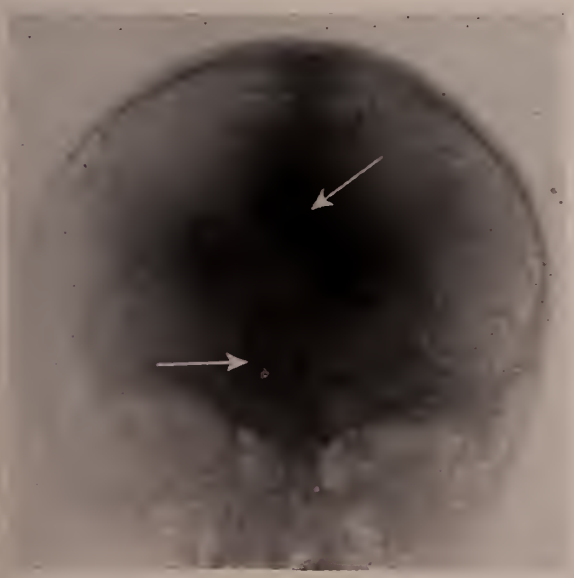


Fig. 5. — Lateral view discloses (1) the middle cerebral artery depressed; (2) lack of filling of ascending frontopolar artery between anterior cerebral and middle cerebral.

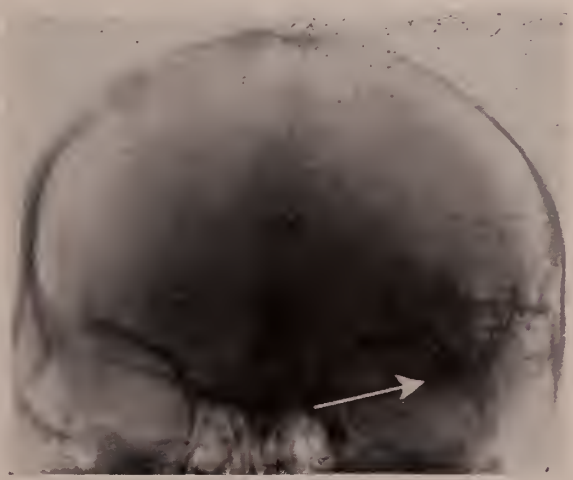


Fig. 7. — Aneurysm of left middle cerebral artery.



Fig. 8. — Aneurysm of left middle cerebral artery.



Fig. 9. — Lateral view shows an angioma fed by the distal portion of the right anterior cerebral artery.

Case 6. — E. B. was a 45 year old alcoholic admitted to Mt. Sinai Hospital in July 1950. He was found in his room with an empty whisky bottle on the floor. He had a 1 inch occipital laceration. On examination, the blood pressure was 140 systolic and 90 diastolic, and auricular fibrillation was present. There was a left-sided weakness. His admitting diagnosis had been "C V A, probably embolism." Plain roentgenograms showed a shift of the pineal body from right to left. Percutaneous arteriography showed displacement of the right middle cerebral artery away from the skull. A large right-sided subdural and intracortical clot was removed. Convalescence was uneventful with full return of function. He has remained well to date.

Case 7.—M. D. was a 69 year old manufacturer admitted to Doctors Hospital in February 1950, with a diagnosis of "C V A" because of sudden onset of left-sided weakness. Five weeks previously he had had a mild bump on the head in a minor car accident. He was confused, with a spastic left hemiplegia and a left Babinski sign. Lumbar puncture showed a pressure of 230 mm. of water with colorless fluid and a protein of 31. Plain roentgenograms of the skull showed a 1 cm. shift of the pineal body from right to left. A clinical diagnosis of subdural hematoma or brain tumor was made. Parietal burr holes disclosed a large, right-sided, oily-appearing subdural hematoma, which was removed. The patient promptly recovered the use of his left side and was up walking about the second day. He was discharged the ninth day and has remained well to date.

Summary

So it is that different pathologic lesions, each requiring different treatment, may produce a stroke. We believe these cases reported demonstrate that one cannot intelligently treat a patient with "stroke" until the underlying pathologic condition is proved.

Cerebral angiography by simply inserting a needle through the skin into the carotid artery is one of the relatively simple methods of visualizing pathologic changes in the brain which affect the blood vessels.

We believe the early use of cerebral angiography in patients who have had "strokes" is more widely indicated. It aids in giving objective evidence of pathologic lesions underlying the "stroke" without entailing a long period of hospitalization as a result of the test.

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Discussion

DR. ALFRED G. LEVIN, Miami: We have had the privilege, during this meeting, of hearing two excellent papers relative to a new diagnostic aid which is justifiably coming into common usage. Yesterday, Dr. Greenfield and Dr. Keedy outlined the principles of cerebral arteriography,

discussed indications and contraindications, described the normal anatomy involved and illustrated that otherwise obscure pathologic processes can often be clearly demonstrated by this new technic. Today, Dr. Strain and Dr. Perlmutter have ably pointed out the specific value of cerebral arteriography in converting a serious and common clinical problem—which previously was considered in a category of "wastebasket" type—into what may now be looked upon as a relatively exact science.

In Dr. Curry's discussion of yesterday's paper the radiologist's participation was thoroughly described, and to avoid unnecessary repetition this discussant's original notes have been discarded. I should like, however, to emphasize the fact that although special training and skill are certainly required of the clinician who is responsible for the conduct of this examination, the technical and diagnostic x-ray aspects are not unduly complex.

There are naturally certain advantages in using especially designed equipment for this purpose, but it is possible and practical to obtain satisfactory films with conventional x-ray units. The interpretation of the films may appear difficult at first blush, but with a little careful study and particularly with the cooperative effort of neurosurgeon and radiologist the issue should rarely be left in doubt.

Dr. Mason Trupp, Tampa: It is fitting that Drs. Strain and Perlmutter in 1951, in presenting their paper, recount for your consideration a technic which was conceived by Egas Moniz, of Lisbon, Portugal, first in 1926, a quarter of a century ago. Today these physicians have described again for you a procedure which has grown in usefulness as a thoroughly investigated diagnostic method which has opened a more thorough approach to the disorders of cerebral circulation and the study and treatment of intracranial disorders, comprising aneurysms, congenital anomalies, neoplasms, abscesses, hematomas, and other space-occupying intracranial lesions. Percutaneous cerebral angiography was first introduced by Loman and Myerson in Boston in 1936. The simple direct method of injecting the vertebral artery as it passes from the foramen in the transverse process of one cervical vertebra to the next is now in common use. The use of 35 per cent diodrast has allowed a readily available, nonirritating, and generally innocuous reagent to enhance the usefulness of this diagnostic method.

Cerebral angiography has made it possible to explore, plan and execute simple, suitable treatment for various intracranial, and in particular intracranial vascular, lesions. The method is applicable in many cases which are considered desperate. Intracranial lesions improperly treated carry a high mortality rate, and any procedure which contributes a more thorough comprehension and a more scientific perspective as to the anatomic pathology which has occurred is of great value. In many cases, surgical treatment is mandatory if irreversible damage to the brain is to be prevented.

In the cases presented, it was necessary to use arteriography five times and ventriculography three times. Even if the arteriogram visualizes a serious intracranial disturbance, it is not always necessary to operate immediately, as in the case of ventriculography. In a ventriculogram, physically incompressible ventricular fluid is exchanged for physically compressible air, so that it is often necessary to move the patient back into the operating room for an immediate cranial exploration. Since arteriography does not confound nor alter blood, brain or cerebrospinal fluid relationships, the cranial specialist and the general practitioner can discuss the case unhurriedly and allow the general practitioner to learn a great deal more about neurosurgery as a specialty.

The general practitioner continues to refer the greatest number of neurosurgical patients, and I have always thought that it has been unfortunate that he has not had an opportunity to become better acquainted with what happens to his patient once the patient leaves his care for the hospital. He too often hears first from the family that the patient has succumbed, or if he is unusually fortunate, he receives a written report from the neurosurgeon at some later date. Arteriography reduces the urgency for cranial surgery, and the general practitioner who will take the time to read some of the excellent articles which are currently appearing in the literature on arteriography will develop a great deal more confidence in handling even the most dramatic cerebrovascular accidents. The essayists have, not without considered judgment, brought to your attention the fact that the patient might have some other lesion, such as a hematoma, an abscess, or a neoplasm, masquerading under the diagnosis of a cerebrovascular accident.

I believe I would be remiss if I were to close the discussion without suggesting that one must be cautious about the rather unscientific and haphazard practice of stellate ganglion injection which has been sweeping this country. Too many of our general surgeons and anesthesiologists have learned to introduce a needle in the neck in the general region of the stellate ganglion and are able generally to perfuse the tissue sufficiently by mass injection to anesthetize temporarily the stellate ganglion. We see patients whose intracranial lesions have been neglected simply because repeated slight improvement was obtained by injection of the stellate ganglion at intervals. It is most disheartening to find that a patient harbors a readily resectible frontal tip glioma or encapsulated tumor which has been allowed to enlarge and spread to involve the speech center and the motor strip simply because intracerebral circulation was repeatedly boosted by interval stellate blocks. I do not disapprove the stellate injection as a valuable method of temporarily improving cerebral circulation under urgent circumstances. On the other hand, I recommend that patients on whom it is performed at least have the opportunity of a neurologic examination prior to the performance of a stellate block.

With your kind indulgence, I should like to show a few lantern slides of patients who had both cerebral arteriography and ventriculography. The first patient is a young Negro in whom a left hemiplegia developed at the age of 39. His father died in his forties of a stroke, and a brother died at the age of 35 of a stroke. The patient was on a work project in Florida, having come from Virginia with a construction team, and after he had lain in the Municipal Hospital for several weeks, his physician asked that he have a neurologic appraisal. Even though the history suggested a vascular accident, arteriography was performed. It is noted that the arteriogram shows no outstanding intrinsic vascular anomaly; the anterior cerebral artery appears deviated past the midline, and the middle cerebral artery and its components appear to be depressed. We therefore followed arteriography by ventriculography and in doing so we observed a shift of the ventricular system on the side in question. On exploration, we were able to remove a subcortical hematoma about 5 cm. in diameter. The patient made a complete recovery and left the hospital on the eleventh postoperative day.

The next slide is that of a 58 year old man in whom a weakness of the left arm developed while he was shaving, standing before a mirror in his bathroom, a not uncommon occurrence. Several days later his grip returned. A week later, however, it was lost again, and increasing weakness developed. Four weeks later the patient had occasion to come into the hospital for removal of a cyst on the scrotum. His physician suggested that an arteriogram be performed during the same anesthesia. The films revealed the carotid artery to be thrombosed in the neck, probably from a thrombosis which occurred in the brain and extended retrogradely. Had the patient been admitted to the hospital several weeks previously, it might have been possible to remove the thrombus from the artery and restore the cerebral circulation. Since the patient deteriorated rapidly while in the hospital, it was thought that a neoplasm might have thrombosed the carotid artery. A ventriculogram showed a shift of the ventricular system consistent with a space-occupying lesion. At craniotomy we removed a swollen, ischemic, necrotic, frontal lobe which extended to the motor strip. The patient remained hemiplegic and will be so permanently. It is rather ironic that serial sections of the frontal lobe failed to disclose any evidence of neoplastic disease.

If we remember that hemorrhages occur often in the silent areas of the brain, such as the right temporal lobe, right frontal lobe, or either frontal tip, and although a cerebrovascular accident has been suspected, in time the lesion will demonstrate its presence by extending into functional portions of the cerebral substance. The condition is occasionally diagnosed as an angiospasm. I believe many of the patients have enlarging cerebral clots which could be removed surgically if we adopted the general policy of performing a cerebral arteriogram on every patient, no matter how small the so-called cerebrovascular accident may appear. If an arteriogram is not performed during the acute stages of a subarachnoid hemorrhage and the true nature of the vascular disorder is not demonstrated and scientifically treated, there often develops a fatal hemorrhage three or four weeks after the initial hemorrhage.

DR. J. G. LYERLY, Jacksonville: The title of this paper would indicate that the discussion would be on cerebral vascular disorders. Evidently the paper is dealing with the differential diagnosis of brain injury, brain tumor, brain abscess, and subdural hematoma, as well as vascular disorders. The diagnosis may be made by neurologic examination, aided by ventriculography and arteriography.

The authors laid considerable stress on arteriograms as a most frequent aid in the diagnosis. It is true that arteriography has gained importance in the past ten years, especially in the diagnosis of vascular anomalies and aneurysms, and more recently in the diagnosis of certain types of brain tumors. It, however, has not supplanted the diagnosis of tumors by ventriculography, but sometimes it is used in combination with ventriculography in making a diagnosis. One gets the impression from the authors that the method of arteriography is without danger, but I do not believe they wish to create the impression that there is little risk involved. In fact, serious complications have occurred such as hemiplegia, convulsions and other types of reactions. With certain precautions, however, and with the use of only 35 per cent diodrast, these complications may be reduced to a minimum. Moniz first used thorotrast for arteriography more than fifteen years ago, and I have used it on many occasions during this period of time for arteriographic work. Since thorotrast remains radioactive and may accumulate in the liver, there may be danger from its use. This has been brought out by several writers on the subject. For that reason I have not used thorotrast for the past five years, but have used 35 per cent diodrast exclusively. It appears to be safe and sufficiently concentrated to give an outline of the arterial tree on the roentgenogram. We are using arteriography routinely in cases of spontaneous subarachnoid hemorrhage and in other types of vascular anomaly and sometimes in cases of brain tumors.

Cancer of the Prostate

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PENSACOLA

Cancer of the prostate is a common form of malignant disease. One out of every seven men 45 years of age or over has a cancer of the prostate, and one out of every two men of this age has a latent focus of prostatic carcinoma which may at any time begin an insidious change into an invasive malignant lesion.[1,2] Furthermore, the incidence increases with the advancement of age so that after the beginning of the seventh decade, almost one third of all men have a prostatic cancer.

Spectacular changes in the longevity of the average person have brought about population shifts which have, in turn, increased the incidence of this malignant disease. Today one person in thirteen is 65 years of age or older, as contrasted with one-half that number fifty years ago. As this trend continues, it is reasonable to assume that the incidence of this malignant lesion will further increase.

In 1947 there were in the United States alone 11,050 deaths reported from cancer of the prostate. This number does not include those patients who had the malignant condition but died of some concurrent illness, or the many in whom the diagnosis was not established. From four to six million men in the United States have prostatic cancer today. These facts are at variance with our clinical experience. How many physicians are able to diagnose cancer of the prostate in one out of every seven men 45 years of age or older? It must be obvious from this discrepancy between the stated percentage and the percentage generally noted by physicians that an early malignant lesion of this gland cannot often be diagnosed with our present methods, or that we are careless or incompetent in our prostatic examinations.

The etiology of prostatic cancer is obscure. Two facts concerning it have indicted "our maleness" itself as a possible inciting factor. First, the known fact that prostatic cancer has never de-

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 25, 1951.

veloped in a eunuch proves conclusively that androgens must be present; second, the subjective and objective improvement in patients with prostatic cancer following castration and/or estrogen therapy is direct evidence of the importance of these male hormones in the maintenance of the neoplasm, at least for a temporary period of time. Recent work by Deming,[3] who succeeded in transplanting prostatic cancer into the aqueous humor of the eye of the guinea pig, led him to conclude that there is a gradual loss of its dependence upon androgens and that the growth assumes, after a time, an autogenetic character. Clinically, this is seen following castration and estrogen therapy.

The posterior lobe of the prostate is stated to be the most common site of origin of this cancer. There is now considerable doubt as to the truth of this statement. It is known that a prostatic malignant lesion may develop in any lobe, and a few investigators have found it to be as common in the lateral lobes as in the posterior lobe.[4] In the great majority of cases, approximately 92 per cent, the cancer does originate in the "prostatic surgical capsule." Some believe that there is a multicentric origin, the original foci being in multiple areas of the prostatic capsular tissue. Since the direct extension of malignant disease of the prostate is somewhat limited by the true capsule, the neoplasm is usually palpable rectally before there is any local extension to the vesicles or base of the bladder.[5]

Once the malignant process begins, metastasis usually occurs early and by three routes: (1) direct extension; (2) hematogenous; and (3) lymphatic through the perineural channels. The most frequent structures involved are those immediately adjacent to the prostate, the periprostatic tissue, the seminal vesicles, and the base of the bladder. Metastases to bone, via the vertebral veins, are common, the pelvis, spine, ribs and skull being invaded in that order of frequency.

There are no symptoms associated with early prostatic cancer. To discuss the symptoms of this malignant condition is merely to emphasize our complete inability to cope with the problem, for once symptoms begin, eradication of the process is hopeless, and palliation is the only choice. Once the process has grown enough to cause dysuria or prostatism, it has extended into the surrounding tissue. Pain in the back and pain in the leg are two common symptoms which usually indicate metastatic lesions. If an early diagnosis is to be made, every man over 45 years of age with or without symptoms must be suspected of harboring prostatic cancer unless careful examination proves otherwise.

Diagnosis

A diagnosis of early prostatic malignant disease is made by careful rectal examination. The availability of a large area of this gland to the examining finger should make this a relatively easy cancer to diagnose. The ease of diagnosis, however, seems to be directly proportional to the stage of the disease. Far advanced prostatic cancer, as a rule, presents a classical picture — irregularity with areas of hardness. A diagnosis of this type is of no more than academic interest if one thinks in terms of cures. Urologists usually think only in terms of palliative therapy because it is known that only 10 per cent of all carcinomas of the prostate diagnosed by them are amenable to surgical extirpation.

Early cancer of the prostate is curable by radical surgery. Diagnostic procedures on the prostate gland should be carried out with this thought in mind. A prostatic examination must be made carefully and systematically. If a diagnosis is to be made when the cancer is small enough to make a surgical extirpation feasible, the physician must scan the gland with his finger in much the same fashion that a pathologist would scan a microscopic section in the search for malignant cells. A tentative diagnosis of cancer of the prostate must be made in any gland in which there is the slightest bit of induration. The most minute irregularity or the slightest degree of hardness must provoke suspicions of a malignant condition. Chronic prostatitis may simulate cancer of the prostate; however, upon repeated careful digital examinations and massage, the indurated areas may soften. A prostatitis at the same time may obscure an underlying malignant area which will only become obvious following massages and the reduction of infection and edema. Prostatic calculi may confuse the examiner, but can be excluded by roentgen examination. The diagnosis can and must be made upon small indurated areas in a large percentage of cases.

A cystoendoscopic examination is an intricate part of the clinical appraisal. Irregularity of the posterior portion of the urethra with or without involvement of the trigone or neck of the bladder is a constant finding in the advanced stages of this disease. An early carcinoma, however, may show

no endoscopic changes whatsoever. At the same time, palpation of the gland over the instrument may aid in determining areas of relative hardness and the degree of fixation if it is present. A cystourethrogram is useful in far advanced cases, but has no diagnostic value in early carcinoma. In all cases, a roentgenogram of the abdomen should be studied for evidence of metastatic lesions and an acid phosphatase test performed. Recent work concerning Papanicolaou smears of prostatic secretion has been encouraging; however, such tests require the services of pathologists who have been particularly trained in the interpretation of the findings. Such personnel are often unavailable.

	PROSTATIC SYMPTOMS	POST OPERATIVE DIAGNOSIS	INCONTINENCE	FISTULA	FOLLOW-UP EXAM
R.S. 58	NONE	ADENO CARCINOMA GRADE III	NONE	NONE	2 YEARS NEGATIVE
G.F. 64	NONE	ADENO CARCINOMA GRADE I	NONE	NONE	2 YEARS NEGATIVE
J.F. 65	NOCTURIA AND BACKACHE 4 MOS.	CHRONIC DIFFUSE PROSTATITIS ATYPICAL HYPERPLASIA	2 MONTHS	NONE	NEGATIVE
C.S. 64	NONE	CHRONIC PROSTATITIS MARKED FIBROSIS	NONE	NONE	NEGATIVE
S.W. 64	NONE	ADENO CARCINOMA GRADE I	NONE	NONE	1 YEAR NEGATIVE
W.E. 60	NONE	ADENO CARCINOMA GRADE II	NONE	NONE	6 MONTHS NEGATIVE
H.T. 60	NONE	ADENO CARCINOMA GRADE III	NONE	NONE	6 MONTHS NEGATIVE
W.H 55	ACUTE COCCAL CYSTITIS - NO PREVIOUS HISTORY	ADENO CARCINOMA GRADE I	NONE	NONE	1 MONTH NEGATIVE

Figure 1.

Treatment

The treatment of prostatic cancer varies with the extent of the growth and may be divided into two groups, depending upon whether the hope is to palliate or to cure. Palliative treatment is reserved for those lesions which can be demonstrated to have metastasized, either locally or generally. It is the present thought among urologists that once the diagnosis of an inoperable cancer of the prostate has been established, orchidectomy with or without estrogen therapy should be instituted. Hormone therapy will, in a large percentage of cases, alleviate symptoms and cause some regression of the growth; however, there have been no cures reported from this treatment. Transurethral resection is reserved for those cases in which obstructive symptoms are present and frequently must be repeated from time to time as the symptoms recur. The results of this palliative treatment are disheartening as far as prolongation of life is concerned. Palliative treatment adds immeasurably to the comfort and health of the patient, but only adds about twelve to eighteen months to the life span as compared to untreated cases.

A suspected cancer which is still confined to the immediate prostate and vesicles should be treated by surgical extirpation. Cancer of the prostate can be cured. The radical perineal prostatectomy as advocated by Young,[6] in which the complete gland, the seminal vesicles, and a cuff of the bladder are removed, is still the treatment of choice in early cancer of the prostate, and is the only method of treatment which offers the patient any chance of cure. Reported series of cases by Young,[6] Hinman,[5] Colston[7] and others have shown that a 50 to 60 per cent cure can be established by this method of treatment.

In a two year period we have performed this radical procedure in 8 cases (fig. 1). In each case the gland presented only minimal findings. There was no fixation in any case, and induration around the vesicles could not be palpated. In each case the lesion was discovered during a routine urologic survey. All of the patients had been referred, and in none had carcinoma of the prostate been suspected by the referring physicians. We believe that if there is any question at all about the diagnosis of prostatic malignant disease in the case under consideration, the patient should be given the benefit of a perineal prostatectomy. Smith[8] stated that "the ideal case for total prostatectomy is a patient whose prostate is so slightly involved as to be of only questionable malignancy."

In our series the youngest patient was 38 years of age, and the oldest 68. Microscopic examination of extirpated specimens revealed malignant disease in 6 cases; in 2 the diagnosis was simple, diffuse, chronic prostatitis. There was no operative mortality. There has been no permanent urinary incontinence, and no rectovesical fistulas have developed. One patient was partially incontinent for two months, but after exercises as recommended by Flaque and others, continence returned to normal. In the first case the patient was operated upon twenty-four months ago, and in the last one month ago. Repeated postoperative checks have revealed no recurrences and no evidence of metastasis. It is certainly too early to predict the salvage rate of these cases, but the absence of recurrence thus far is, at least, most encouraging.

Summary

Cancer of the prostate is a common malignant disease. The reported incidence varies from 14 to 46 per cent of all men past the age of 45 years.

In this age group careful rectal examination may reveal small areas of induration varying in degrees of hardness, which must be regarded as carcinoma unless proved otherwise.

Orchidectomy and estrogen therapy offer palliation of symptoms and temporary regression of the growth in the majority of cases.

The total perineal prostatectomy, if performed on early lesions, will result in a cure in 50 to 60 per cent of the cases.

A series of cases is presented and briefly discussed. In all, the patient had undergone a radical perineal prostatectomy for what was believed to be an early neoplasm.

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Discussion

Dr. E. Clay Shaw, Miami: It has been a pleasure to hear this young Florida urologist report his series of radical perineal prostatectomies. At the rate that he is going, within a few years he not only will have a formidable array of statistics, but he will also have a group of men who literally owe their lives and comfort to his skill and progressive attitude. To my mind, the treatment of early carcinoma of the prostate is the most neglected phase in the specialty of urology. Only 5 to 10 per cent of the cases are diagnosed early enough to allow any hope for a cure by surgery. On the other hand, to make matters worse, many urologists are unwilling to subject the patient, in cases in which they are able to make a diagnosis of early carcinoma of the prostate, to radical surgery despite the fact that radical perineal prostatectomy is followed by a five year survival rate of over 50 per cent and a ten year survival rate of 30 per cent. When it is considered that the majority of patients operated on are in their sixth and seventh decade of life, such survival rates compare favorably with the results of radical surgery in any other part of the body. The combined statistics reported by a group of authors indicate a mortality rate of approximately 7½ per cent.

The severity of the procedure is certainly less than in many of the well accepted procedures for malignant disease of the stomach, intestines, esophagus, lungs and other organs of the body. The operation is necessarily followed by the almost complete invariable loss of the power of erection, but fortunately in many of these older men this is not a matter of great concern. At any rate, castration and estrogen therapy also usually terminate a man's sexual life.

A rectal examination should be a part of any complete physical check-up. We have had an increasing number of patients referred to us by internists and general practitioners who come in without symptoms and only because a nodule was found in the prostate on a complete physical examination. The diagnosis may be difficult, and we advise perineal biopsy, should doubt persist after a reasonable period of observation. Needle biopsy has not given satisfaction in most hands. A positive report is helpful, but a negative one may merely mean that the tissue was taken from the wrong place. The open biopsy is not a formidable procedure and may be readily done after exposing the posterior prostatic capsule through the regular incision for perineal prostatectomy. In some instances, after a thorough inspection and visualization of the area in question, it is found that a biopsy is not needed. We have observed at times that pathologists are reluctant to give a definite report from frozen sections. In some cases in which the evidence has not seemed sufficiently strong to proceed with the radical operation, we have taken an adequate amount of tissue from the suspicious area for permanent sections and closed the incision. Should the section prove the absence of malignant disease and should the patient not have sufficient symptoms to justify prostatectomy, he may usually go home in forty-eight hours after the biopsy is made, with little ill effect. I have never seen a patient's sexual powers affected by a prostatic biopsy.

To the urologists of this group I recommend for your consideration a procedure that has been employed in our office for the past several years. All male patients beyond the age of 50 are urged to come in for an annual rectal examination. By comparing the findings from year to year, we have been able to detect nodules earlier and we have been able to increase the operability of carcinoma of the prostate in our private practice to nearly 35 per cent. In my opinion, a persistent indurated nodule in a man's prostate calls just as strongly for a biopsy as a similar nodule in a woman's breast, and a positive diagnosis of malignant disease calls as strongly for radical surgery in one instance as in the other.

Dr. Perry, concluding: Thank you, Dr. Shaw. I appreciate the honor of having been on this program and having had an opportunity to speak about what I think is one of the most important problems in the field of cancer therapy today. The ultimate end of this problem rests in your hands. The early diagnosis of malignant lesions of the prostate is usually not made by the urologist, and it is the referring physician who gives him the opportunity to treat the patients with this disease. Thank you.

Seventy-Eighth Annual Convention
Florida Medical Association
Hollywood, April 27-30, 1952

Volume XXXVIII
Number 6

Disabling Conditions of the Cervical Spine

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The complaint of pain in the neck and shoulders with extension into the arm is of relatively frequent occurrence and has almost superseded the low back as the "problem child" of the musculoskeletal system. Patients with this complaint consult not only the orthopedic surgeon but the general practitioner as well. The causes of this disability are many and varied; but in general the pain arises from the cervical spine and its supporting structures, and is referred over the shoulder and possibly down the arm; or it may come directly from the shoulder girdle itself. It is believed that the cause or combination of causes which can bring on these symptoms is not widely understood. The purpose of this paper, therefore, is to review the various etiologic factors that may produce cervicobrachial pain and, in particular, to stress certain aspects of the diagnosis and treatment of the most common and obstinate of these factors.

As with any condition in medicine or surgery, no intelligent treatment can be initiated without an accurate diagnosis; and one can make no accurate diagnosis without first analyzing a carefully taken history and carrying out a systematic and painstaking physical examination, particularly of the upper portion of the spine, the shoulder girdles and the upper extremities. In addition to these measures, necessary roentgen studies should be made, as well as laboratory examinations when indicated. Particularly must one realize that the pain may not arise in the cervical spine or shoulder girdle, but may be referred from the thoracic or abdominal organs, as in diseases of the apex of the lung or an irritative process in the region of the diaphragm, or may be caused by herpes zoster.

In the differential diagnosis of pain in the neck and shoulder, experience may be fallacious and judgment difficult. The pain may be simply an annoyance or a symptom of serious disease. Too often, because of inadequate examination and incomplete diagnosis, the patient receives everything from aspirin to balneotherapy, from colonic lavage to dental extraction, diathermy, diets, vitamins and/or operation. This type of patient wanders from physician to physician and often to cultists, and still the pain persists.

To avoid confusion, we have omitted consideration of patients with symptoms resulting from pathologic changes in the shoulders, such as subacromial bursitis and tears in the musculotendinous cuff. We wish to emphasize, however, that lesions of the shoulder girdle may initiate cervicobrachial pain by concomitant diffused muscle spasm accompanying the lesion. Such pain may likewise follow voluntary splinting of the affected arm with depression of the painful shoulder, as frequently occurs after trauma.

The common lesions arising from the cervical spine and giving pain in the neck and shoulder are:

1. Muscular and ligamentous strain
2. Hypertrophic arthritis of the cervical spine
3. Subluxation of the cervical spine
4. Fracture or dislocation
5. Neuritis of toxic origin
6. Herniated intervertebral discs
7. Cervical rib and scalenus anticus
8. Raynaud's disease
9. Tumors
10. Postural and anatomic conditions with vascular and nerve compression

Tenderness or limitation of motion of the cervical spine, when present, should induce one to investigate further to determine whether or not this region may account for the symptoms. Certainly, the cervical spine should be examined routinely in all cases of painful shoulder in which there are insufficient signs to verify the diagnosis of local

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 24, 1951.

lesions in the shoulder, or of neuritis. The absence of restriction of motion, or pain at the extremes of motion, and the absence of a definite point of local tenderness rule out lesions of the shoulder joint as the cause of pain.

Following the careful examination of the neck and shoulder, roentgenograms of the cervical portion of the spine should be made. These should include an anteroposterior view with the mouth open, a lateral view with the neck in a neutral position of flexion and extension, a lateral view in extreme flexion, and bilateral oblique views. The roentgenograms permit division of the patients into two groups:

A. Those with structural abnormalities such as: cervical rib, Klippel-Feil syndrome, fracture or gross dislocations, or arthritis.

B. Patients with roentgenograms giving negative or normal evidence; or with roentgenograms showing a flat cervical spine, or one in which there is a reverse curve.

It should likewise be stressed that abnormalities demonstrated in the roentgenogram are not necessarily the sole cause of complaint, since in the average patient certain variations may have been present for years without causing symptoms. But at least such anomalies are suspect and factors to be considered.

Diagnostic Problems

It is not within the scope of this paper to discuss the details of all the factors entering into the diagnosis and treatment of patients with cervicobrachial pain, as they have been considered in the literature. It is pertinent, however, to comment on some aspects of the diagnostic problems and the treatment of these problems.

One of the most frequent causes of discomfort in the neck is that occasioned by the acute or subacute stiff neck or wryneck, which is most often due to strain of supporting structures and is frequently complicated by toxic or infectious myositis. This situation commonly is present as the patient awakens after a night's sleep and is due to long malposition of the neck on a pillow, perhaps complicated by exposure to a draft; or it may come on as the patient stretches and strains the muscles of the neck shortly after awakening. Many times the pain is extremely severe; it is usually localized, and may travel over the shoulder. There may be a fixed painful torticollis, and any attempted motion is intolerable. If the torticollis is pronounced, a roentgenogram will give a false distorted view and is, therefore, not of definite value.

In those cases in which the torticollis is severe and associated with great pain, a simple office procedure is sometimes of inestimable value in giving the patient immediate relief. The patient is given a moderate dose of sedative and is placed on a table on his back with the head and neck and upper portion of his shoulders extending over the end of the table. The head is held by an assistant or member of the family for the first few minutes of the treatment while the narcotic is taking effect and relaxation of the muscles is being obtained. The support is gradually released until the patient's head is hanging off the table without any support. This procedure is continued until complete relaxation of muscles is obtained. With the patient in this relaxed position a voluminous felt and sheet wadding collar is applied, and this may be strengthened with either cardboard or plaster of paris. The patient is then gotten up gradually and allowed to return home to bed. The collar is continued thereafter in hyperextension for a period of one to two weeks. Injections of novocain and heat to the neck may speed up the period of recovery. If the pain persists, traction in the horizontal or vertical planes may be instituted at regular intervals. In a matter of a week or so, however, this type of pain in the neck usually subsides. If symptoms are particularly severe and prolonged, roentgenograms should be taken in a few days to rule out a more severe pathologic condition of the cervical spine.

The subject of fractures and dislocations, herniated intervertebral disc, cervical rib and scalenus anticus syndromes, tumors and vascular disorders, and neuritis, per se, in the cervical spine has been adequately covered in the literature and is mentioned here only as a refresher to the memory. The history, physical examination and roentgen studies should bring to light these lesions if they are present; and they must be considered by the physician in any long-standing or persistent case of cervicobrachial symptoms.

Hypertrophic osteoarthritis of the cervical part of the spinal column may, in and of itself without gross impingement on a nerve root, be responsible for a variety of cervical symptoms. Chief of these is usually pain and stiffness of the posterior part of the neck, particularly on arising in the morning. It may be referred to the occiput, to the back of the shoulders or even into the arms. The reference of pain is not necessarily due to irritation of the nerve roots, per se. In the more severe arthritic cases there may be some impingement on a nerve

root; however, it is rare to see impingement on a nerve root due to foramenal compression much before the age of 35 to 40 years.

It must be stated frankly that the mechanism of impingement on nerve roots is still obscure. This obscurity is obviously due to the fact that it is not possible to see by direct vision the changes responsible for the impingement. Many interesting suggestions have been offered. These hypotheses can be best understood if one first considers briefly the anatomy of the cervical intervertebral foramen.

The foramen is bounded anteriorly by the posterior surfaces of the vertebral bodies, which are covered by the posterior longitudinal ligament. The upper and lower margins are formed by the concave borders of the pedicles of the superjacent and subjacent vertebrae. The posterior margin is the synovial membrane and the ligaments of the apophysial joint. It has been suggested by some that the foramen may be narrowed by a breakdown of any of the tissues that normally hold in place the bones that form the foramen. Thinning of an intervertebral space or cushion may represent such a breakdown. Whatever the cause of the thinning of the cushion, it is obvious that if the space between the vertebrae diminishes, the height of the foramen diminishes. The associated forward displacement of the superior articular process of the subjacent vertebra which occurs must, of necessity, cause similar decrease in the lateral diameter.

In the cervical portion of the spinal column degenerative changes in the intervertebral cushion occur most frequently from the fifth to the seventh cervical vertebrae. The fact that the nerve roots associated with these vertebrae are larger than the upper cervical nerve roots may explain the frequency of radicular symptoms originating at these levels. It has been thought that spur formations and bridgings are secondary irritative phenomena incident to the narrowing of the discs and the approximation of bony surfaces. It has been suggested that the foramen may be encroached upon and narrowed by the formation of bony or inflammatory tissue. Into this group may fall primary apophysial arthritis with a resulting thickening of synovial, ligamentous and periosteal structures. This concept may explain the manner in which a single trauma, chronic trauma, postural strain or malalignment may produce radicular irritation. One must also accept as a possibility a posterior arthritic exostosis appearing in such a location as to encroach on a foramen.

It has been further suggested that whichever mechanism is accepted as the one producing the narrowing of the intervertebral foramen, one must conclude that it is but a predisposing factor and that there is an additional inflammatory element superimposed on it. Otherwise, one could not explain the lasting beneficial effects of traction or high voltage roentgen radiation that have been produced clinically. One cannot expect traction or roentgen therapy permanently to restore the thickness of a thinned intervertebral disc, or to reduce the size of an exostosis. There must be an added inflammatory factor. Traction affords relief by temporarily increasing the size of the foramen and allowing the "neuritis" or inflammatory reaction to subside. Similarly, high voltage roentgen radiation reduces the edema and congestion of inflammatory tissue and by so doing promptly increases the foramenal space.

Whether the cause of impingement on a nerve root is the bony narrowing of the foramen, an exostosis, the narrowing of the foramen due to inflammatory encroachment, or the thinning of an intervertebral cushion, the clinical picture is always characteristic. The symptoms are much more frequently referable to the lower cervical than to the upper cervical region of the spinal column from C4 to D1. The type of symptoms produced is influenced also by the amount of impingement and the portion of the nerve root involved. Sensory changes are more frequent than motor changes. This difference may be due to the fact that the motor fibers of the anterior cervical roots are fewer than the posterior sensory fibers, and are about one-third the size of the latter. The degree of impingement may cause a variety of sensory changes: paresthesias, numbness, or severe and intractable pain. Similarly, if the motor fibers are involved, there may be reflex changes, loss of strength, atrophy and even flaccidity. The patient usually carries the head stiffly and resists whichever cervical motion accentuates the pain. Pain is usually worse when the patient is in the recumbent position. It is not uncommonly so severe that ordinary doses of narcotics are of little help.

Cervical Myo-radicular Syndrome

With these factors in mind we wish to talk about the most common clinical entity which is found in those patients complaining of pain in the neck and shoulder girdle. For descriptive purposes we have named this condition "the cervical myo-radicular syndrome." This term designates a

clinical entity characterized by pain in the cervical region and/or those structures attached to the cervical spine by myofascial connections. Generally, there are varying degrees of limited motion of the neck associated with tender trigger points, and a loss of the normal cervical lordosis, with or without partial subluxations and/or narrowing of certain of the intervertebral disc spaces. Furthermore, this clinical entity may arise as the result of an injury or without the patient's knowledge of a specific injury. This question of injury, whether recent or remote, is frequently slurred over by the patient for the reason that painful symptoms do not develop until some time after the injury — from a few days to several months and a good many times years after the injury.

The high incidence of injury as the etiologic factor and the acceptance of the fact that the great majority of injuries of the cervical spine are in the nature of a whiplash or reverse whiplash make the nature of a great variety of injuries of this section of the spinal column more easily understandable, especially if we define the term whiplash as a hyperflexion of the cervical spine followed by a spontaneous extensor recoil. In addition, we should state that the reverse whiplash consists of hyperextension followed by a spontaneous flexor recoil.

The extreme mobility of the cervical spine and its known potential for dislocation unaccompanied by fracture make it extremely susceptible to injury. Two degrees of injury are immediately separated by the severity of the accident. These might be referred to as obvious and obscure types of injury. This paper deals only with the obscure lesions, that is, those lesions included in the cervical myo-radicular syndrome.

As increasing degrees of the hyperflexion force are encountered, not only are the fibers of the capsule of the articular processes ruptured, but also the posterior common ligament, with presumably some fibers of the annulus fibrosis. When rupture occurs, the pivot of motion is no longer at the junction of the pedicle and body, but shifts forward to the anterior lower border of the dislocating vertebra. This border then impinges on the border of the subjacent vertebra as the articular processes of the dislocating body mount the processes of the subjacent body. Because of the injuring force and the extreme mobility of the cervical section of the spine, any degree of injury must be anticipated from sprain, involving the tearing of a few fibers of the posterior articular ligaments, disc injuries and complete dislocations, to complete severing of the cord. It is the lesser degrees of injury which have eluded specific diagnosis to date.

Following the obtaining of the history and a careful physical examination, roentgen examination of specific type is indicated in obtaining a workable diagnosis. In addition to the anteroposterior projection with the mouth open, two additional attitudes with the patient in the sitting position are assumed and lateral projections of the cervical spine are obtained; one is made with the patient relaxed and the gaze focused on a point level with the eye, and the other with the head pushed forward to approximate the chin as near the chest as possible in order to obtain maximum range of flexion of the neck.

Immediately following an injury such as those mentioned, the elastic extensor recoil mechanism provided by the static posterior cervical musculature and the ligamentum flavum is the mechanism which serves to conceal the damage which has occurred, since it affects a variable degree of reduction spontaneously. Spasm of the cervical musculature serves to avoid painful contact of the injured parts; therefore, the facets are not restored to their normal apposition. The entire cervical spine is held slightly forward to avoid such painful contact of the posterior articular processes. This forward displacement, plus the inflammatory reaction set up by the original trauma, causes the typical symptom complex. Elimination of the normal forward curvature thus produced provides the clue to the damage concealed by the spasm. If in such cases the patient is seen immediately afterward and the lateral projection shows a straight cervical spine, a picture should be taken in the chin-chest position. In a great many cases of this type, however, there are only fleeting symptoms which disappear in a few days, and the patient resumes the normal use of his head and neck. Doing so is a mistake, for in exactly the same manner as with a neglected sprain of an ankle, such torn ligaments heal in the elongated position. Normal use thereafter continues to stretch the ligaments, accounting for the increasing disabling symptoms occurring from three months to years afterwards. Such neglected cases result in pain in the cervical region with variable amounts of radiation.

With the clue to mechanical derangement established by the fact that the cervical spine exhibits a straight line in the neutral lateral projection, and a specific level of angulation in the chin-chest



Fig. 1. — Cervical traction in hospital type bed with roll under neck and semi-Fowler's position.

projection, differential diagnosis depends on a proper correlative evaluation of the roentgen and clinical findings. Bilateral oblique views of the cervical spine to show the intervertebral foramina may, in addition, reveal a lesion of one of three kinds:

1. Luxation of the posterior facets
2. Narrowing of the intervertebral disc space
3. Lesions encroaching on the intervertebral foramen
4. Combinations of any two or all three of these

Localization of the lesion may be obtained by correlating the point of forward angulation of a cervical vertebra and the pattern of the radiation of the pain.

In those cases which present a similar clinical picture of stiffness, pain, tender trigger points and radiation into the shoulders, but in which the etiologic factor is not so easily discovered, many times there are similar roentgen findings, and treatment is similar.

It is our practice in those cases which have been involved in such severe injuries as the head-on or rear type of collisions to place the patients in traction and gradual hyperextension over a neck roll (fig. 1) for a period of approximately a week and then to let them become ambulatory in a cervical collar (fig. 2). They are seen at intervals in the office, where they are given diathermy, traction and massage, and, if necessary, novocain injections of any trigger points which may be present. Traction at home at night (fig. 3) is continued, with a roll under the neck. As the symptoms decrease, the traction and office therapy are gradually decreased until the patient is receiving no treatment in the office. We have these patients continue, however, to use a roll under the neck rather than a pillow until we are sure that they are remaining asymptomatic. Roentgen check in the lateral projection is made occasionally to assure the return of the normal curve of the cervical spine.

Those patients who have definite evidences of narrowing of the foramen with segmental compression of the nerve roots are treated also by traction for a more prolonged period and are gotten up in a collar or brace. If the symptoms are of long standing and are relieved by the traction-hyperextension and maintenance of this hyperextension, fusion of the involved areas is of definite benefit in most cases. Cervical ruptured intervertebral discs, when diagnosed, are removed if conservative methods fail. In view of the rocker movement characteristic of the cervical vertebrae, it is illogical to separate lesions involving luxation of the posterior articulations from those of the disc, and vice versa. Injuries affecting the one inevitably involve the other, since the vertebra moves as a whole.



Fig. 2. — Albee collar for support while patient is ambulatory.



Fig. 3. — Traction apparatus as adapted for home use.

Conclusion

Judging from the mechanics of the injury, and the remarkable persistence of symptoms, it would appear that further investigation and studies of end results are necessary to understand fully this symptom complex and to formulate a satisfactory treatment for those patients suffering from the symptoms of the cervical myo-radicular syndrome.

Present day roentgenologic, neurologic, and orthopedic technics, however, when combined, permit a more favorable prognosis in patients with the cervical myo-radicular syndrome type of complaints. The majority of them consult physicians other than the orthopedic surgeon, and a specific regimen for the handling of these patients will do much toward attaining the goal of increased knowledge of this syndrome as well as giving the patients much needed relief.

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Dr. J. G. Lyerly, Jacksonville: I should like to congratulate Dr. Albee on his excellent paper. My discussion will be limited to nerve root pressure, associated with cervical intervertebral disc syndrome. In this condition the patient suffers pain in the neck, the shoulder, and then the arm. There is a radicular pain with radiation along the course of the involved nerve root. The most frequent location for a cervical dislocated disc is at the level of the sixth or seventh cervical intervertebral disc. In nearly all cases of this type the patient has radicular pain with numbness, tingling, or pain along the radial side of the forearm to the thumb, and the index and middle fingers. Associated with this pain there may be weakness of the triceps muscle with absent triceps jerk. Of course, if there are other cervical discs involved either above or below this level, there will be other nerve roots involved with localization of symptoms.

In many patients the cervical disc syndrome may be caused by bony spurs compressing the nerve root at the intervertebral foramen. But this is a mechanical factor and may require identical means for relief. To complete the diagnosis, I think most cases of this type will require a pantopaque myelogram using 6 cc. of the pantopaque to get a good outline of the cervical spinal canal. If there is a definite defect at a cervical intervertebral disc level corresponding to the neurologic changes that the patient presents, surgery would most likely be advised. Surgical removal of the dislocated disc may be the quickest method for relief, since it would shorten the hospital stay from one to two weeks. Yet in atypical cases more conservative treatment with head traction may be recommended. Frequently traction is applied with a halter, using as much weight for the traction as the patient can stand, continuously for a week or ten days in the hospital. This gives the patient relief temporarily. After the patient goes home, the traction may be continued part time. Surgery, however, may be required if this method of treatment does not give relief after the first week.

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On Data of Notable Interest

Fat Embolism: Report of a Fatal Case

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It is worthwhile to bring before the medical profession, from time to time, the subject of fat embolism, a not rare but often overlooked condition which is a significant cause of death in trauma. Fat embolism was produced experimentally in dogs by Magendi in 1821, and the first human case was described by Zenker in 1862.

Incidence

There is a direct relation of fat embolism to trauma. Of the last 100 cases reported by the Army Institute of Pathology, 91 followed fracture of the tibia or femur; 4 were caused by blast injury, 3 by burns, and one each by pressure asphyxia and skull injury. In 6 per cent of 1,000 battle casualties death resulted from fat emboli. Pulmonary fat emboli were found in 50 per cent of a series of fatal cases of trauma. The finding of pulmonary fat emboli alone is not pathognomonic for the condition because it has been shown that fat is found in the lungs in many routine autopsies. Denman and Gragg cited Wyatt and Foo as showing pulmonary fat emboli in 30 consecutive cases in which death was due to trauma. In a similar number of nontraumatic cases no appreciable amount of fat was found.

Pathogenesis

There is still some difference of opinion as to the origin of the fat in fat embolism. The majority of authors favor the idea that neutral fat of the bone marrow enters the gapping venous channels in the region of the fracture and then plugs the vessels of the lungs, some filtering through the lungs to the brain. The increased local pressure due to swelling is cited as a factor. The lethal dose of neutral fat is 12 to 120 cc. The fat in the femur is approximately 65 cc. Experimentally, death can be induced in rabbits by a proportional injection of neutral fat.

Fat is poorly tolerated by the brain and to a slightly better degree by the lungs. The kidneys are not affected and excrete the fat without damage.

Symptoms

Accidental injury with initial shock is followed by a symptom-free period which may extend for thirty-six hours. This is followed by the onset of pulmonary symptoms, such as edema, dyspnea and cyanosis, and cerebral symptoms, which include irritability, excitability, psychoses, convulsions and coma. A careful search will frequently reveal petechial hemorrhages of the skin of the head, neck, upper part of the chest and ocular fundi. These latter findings are considered most important by many clinicians. Attempts to demonstrate fat in the urine, blood and sputum have had only partial success. The reaction of the spinal fluid is negative. The temperature may be markedly elevated. The fundi do not reveal fat; petechial hemorrhages may occur. Roentgen examination of the chest shows a general haziness characteristic of pulmonary edema.

Pathology

The findings are not outstanding, and therefore in many cases the fat emboli are overlooked. The lungs may have oily droplets. Pulmonary edema is definite. Petechial hemorrhages of the brain and the skin of the head, neck and chest are fairly constant findings.

Microscopically, fat is found in the small vessels and capillaries of most tissues, predominantly in the lungs, kidneys and brain. The cerebral cortex has minute areas of perivascular demyelinization and necrosis surrounding the plugged arterioles. The fat does not appear to break down.



Fig. 1. — Fat embolus of the brain. (H.P.)

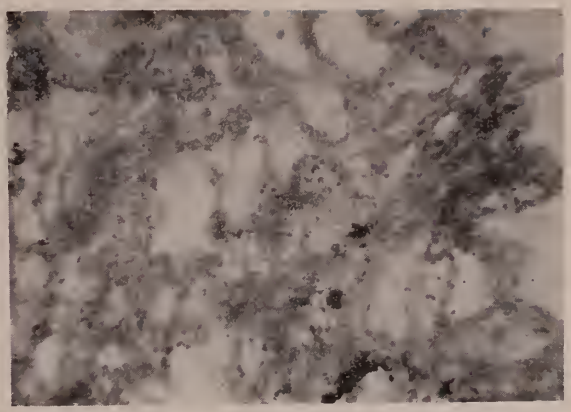


Fig. 2. — Fat emboli in the lungs. (H.P.)

Treatment

Prophylactically the splinting and careful transportation of fractures of long bones should be practiced. The avoidance of manipulation and the elevation of fractured limbs would appear to be of value in the prevention of local edema and increased pressure. The use of a tourniquet proximal to the fracture and venous bleeding there would seem to have merit. The drainage of the medullary canal is a possible practice. Oxygen is the mainstay of supportive measures.

Prognosis is reserved. Probably only the severest cases come to autopsy. There are several reports of recoveries in well developed severe cases.

Report of Case

S. C., a man aged 65, was admitted to Jackson Memorial Hospital shortly after being struck by a car. His chief complaints were pain, disability and deformity of the right leg.

General examination revealed no abnormalities other than a comminuted compound fracture of the right tibia and fibula, with a relatively small puncture wound on the anterior medial aspect. The wound was irrigated with normal saline and a furacin dressing applied. Reduction was carried out under general anesthesia; a long leg cast was applied with the knee in flexion of 45 degrees. Check-up roentgenograms showed inadequate reduction, and the cast was wedged in an attempt to improve further the position. On April 4, 1950, the last of these check-up roentgenograms showed that alignment was good, but that little apposition was present between the ends of the tibia and further procedure would be necessary.

Two days later roentgenograms revealed multiple fractures involving the fifth through the ninth ribs on the right side with great displacement of some of the fractured fragments. On April 7, the general condition seemed good, and the chest was clear. The patient was taken to the x-ray department, where manipulation was again carried out under general anesthesia in an attempt to avoid an open reduction. Although there had been some bright blood on the dressing, there was no active bleeding present from the compound wound. The manipulation was carried out without incident, and a long leg cast was applied. He experienced no difficulty in taking the anesthetic. While roentgenograms were being taken, and after the anesthetic had been discontinued, it was noted that the patient did not seem to be breathing, and all efforts to revive him failed. He remained pink and was never cyanotic. It was believed that his demise was due to an embolus.

Autopsy Findings. — The pertinent autopsy findings were a compound fracture of the right tibia and fibula, and moderate contusions of the right shoulder and elbow. Pulmonary edema and congestion were moderate. Cerebral edema was moderate and petechial hemorrhages were noted in the white matter. They were tiny in size and diffuse. The microscopic examination showed numerous globules of fat in the terminal arterioles of the brain, lungs and kidneys as revealed by Sudan III stain (Figs. 1 and 2).

Conclusion

A fatal case of fat embolism is presented, and the subject is discussed with a view to pointing out anew the occurrence of this anomaly in civilian practice. Tender and careful handling of long bone fractures is indicated to prevent this complication.

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Intra-Abdominal Lymphangioma

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Lymphangioma of the mesentery was first reported in the American surgical literature more than half a century ago. Since then periodic reports have appeared in the literature,[1-7] a survey of which leads us to believe much confusion exists in regard to lymphatic growths. Singleton,[6] in an excellent discussion of lymphangiomas, designated three types, simple or capillary, cavernous and cystic. In general he described the lymphangioma as a tumor of lymph vessels and spaces containing lymph and lined by endothelial cells. Lymphangiomas occur as single or multiple growing masses of varying size and weight and are encountered in all systems of the body.

Lymph cysts of the abdomen arise from lymph sacs of the retroperitoneal area, and according to Keith,[8] who cited the work of Huntington and McClure, they originate from retroperitoneal lymph centers at the root of the superior mesenteric artery. The factors responsible for their growth remain a matter of conjecture, although trauma and embryonal rest have been implicated.

The index of suspicion of mesenteric cysts in the differential diagnosis of intra-abdominal tumors is low because of their insidious asymptomatic course and because of their rarity. We present 2 cases of mesenteric lymphangioma; in 1, a diffuse multiple growth occurred in a 51 year old white man, and in the other a single tumor in an 8 year old Negro boy.

Report of Cases

Case 1. — A white man aged 51 years, a salesman known to one of us (R. R. K.) for many years, complained on May 20, 1950 of fulness in the abdomen of six months' duration, which had gradually increased in severity and had become associated with severe abdominal cramps. There was a history of uneventful recovery from pneumonia ten years previously and from an appendectomy four years prior to this examination. At the time of the operation, which was performed through a right rectus incision, observation disclosed no evidence of other disease processes. Three sigmoid polyps had been removed through an operating proctoscope two months before the onset of the present symptoms. Because of obesity, the patient having weighed 206 pounds on July 26, 1949, a reducing regimen and diet had been prescribed.

On physical examination, the weight was 171½ pounds. The significant findings were limited to the abdomen, which was pendulous but symmetrically enlarged. The edge of the liver could not be palpated with certainty. An intra-abdominal mass, somewhat fixed and nodular but of undetermined character, could be palpated about the umbilicus. It was slightly tender on deep pressure and did not move with respiratory excursions. A fluid wave could not be elicited. Proctoscopic examination gave negative results.

Urinalysis and complete hematologic studies, repeated on several occasions, gave negative evidence. Roentgen studies of the chest, heart, gallbladder and gastrointestinal tract revealed only that the gallbladder was high in position and that the stomach also was high in position and rotated upon itself.

Preoperative diagnosis was not made with certainty. The differential diagnosis, however, included neoplasm of the stomach, pancreas, colon, adrenals and kidney. Having in mind a somewhat similar case in which the patient was operated upon by one of us (R. R. K.) in 1944, we also gave consideration to possible mesenteric or omental cysts.[9]

At operation on June 8 at St. Luke's Hospital, the abdomen was opened through a large left paramedian incision. Immediately, large clear-like cystic masses varying in size and shape from B.B. shot to large grapefruit were encountered. A clear amber fluid escaped from a few that were incised. A survey of the intra-abdominal organs revealed no pathologic changes other than the presence of these cystic masses attached to nearly all organs from the diaphragm to and including the pelvic cavity and throughout both lateral gutters. Complete removal of the cysts was accomplished. The largest ones were situated near the root of the mesentery (fig. 1) just beyond the origin of the superior mesenteric vessels, and there was gradual diminution in size as they extended toward the periphery. As indicated by the arrow in figure 1, the pedicle for the cysts appeared to originate at the root of the mesentery. To be certain, however, that it did not originate from the urachus, a portion of this structure was removed. Over a gallon of fluid was siphoned off during the operation. The abdomen was closed in layers in the usual fashion.

The patient made an uneventful recovery. When he was weighed ten days postoperatively, there was a loss in weight of 25 pounds. He has since remained in excellent health.

The pathologic report, made by Dr. James Wallace, follows:

"The specimen was weighed immediately after operation, and the weight was 5,012 Gm. The specimen consists of a multicystic neoplasm. The cysts measure from 1 mm. in size up to 14 cm. in greatest diameter. Many of them are unilocular; however, the larger ones tend to be multilocular. The outer surface is smooth and glistening, and the lumina of the cysts contain pale yellow fluid. The inner lining of the cyst is also smooth and glistening. No papillary structures are noted. The cysts are held together by vascular channels and fibroconnective tissue.

"Microscopic Description: Multiple sections through the cystic elements show that they are composed of multilocular structures that are separated by fairly thin fibroreticular walls in which there is a modicum of chronic inflammatory cell infiltration. Several of the cysts contain what appears to be a true endothelial lining, and there is no evidence of hemorrhage within their lumina. A precipitated type of protein is occasionally noted. One or two areas contain in the center of the cystic areas what appear to be poorly formed epithelial-lined glandular elements that have no ducts and occasionally no lumina, these being somewhat suggestive of hamartomata. For the most part, however, the specimen is made up of thin-walled

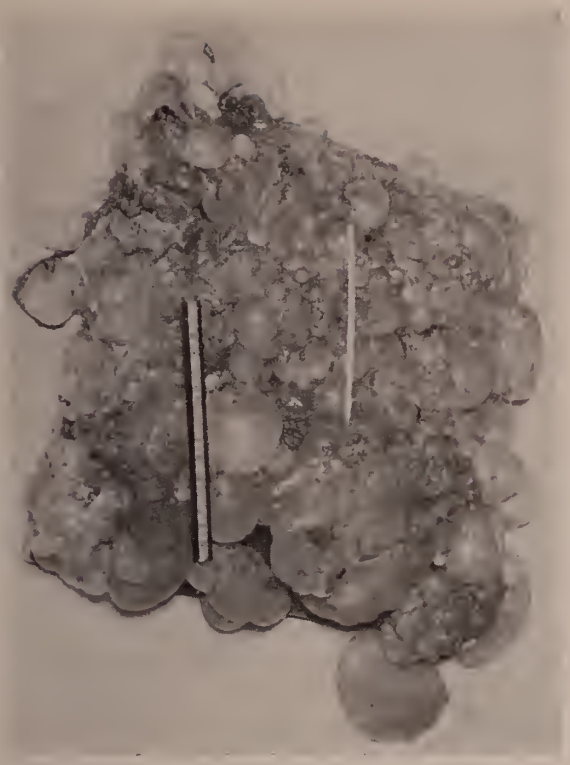


Fig. 1. — Photograph of the tumor mass in Case 1, taken immediately after the operation.

cysts, and occasional areas of epithelial or epithelial-like structures are noted. One or two areas show interstitial hemorrhage in the walls of the cysts.

"Sections from the region of the urachus show a similar type of structure with a single exception that here there is apparently some infiltration of the endothelial elements.

"Diagnosis: Cavernous cystic lymphangioma of mesentery."

The slides were sent to various pathologists, including Dr. Harry S. N. Greene of the Department of Pathology, Yale University. That the tumor was a lymphangioma, cavernous in type, appears unchallenged. In our opinion it originated from the root of the mesentery.

Case 2. — An 8 year old Negro boy was admitted to the Duval Medical Center on Aug. 10, 1950 with the chief complaint of pain in the abdomen, nausea and vomiting. For three weeks he had experienced intermittent bouts of abdominal pain associated with nausea and vomiting, which had subsided spontaneously, causing little disability. About twenty hours prior to admission he had awakened with crampy abdominal pain and had vomited repeatedly. The father then noticed a mass in the upper part of the child's abdomen; both he and the mother stated they had not observed it previously. There was no history of hematemesis, melena, mucoid stools or other contributory data.

Physical examination revealed no abnormality except a mass in the upper portion of the abdomen somewhat to the left of the midline measuring 12 by 15 cm. It was firm, tender and freely movable from side to side and to a lesser extent up and down.

Roentgen examination of the abdomen in the upright position revealed gas in the large and small intestines, but there was no distention. Hematologic studies, urinalysis and examination of the stools for ova, parasites and occult blood gave negative results.

At operation, performed by Dr. Duncan B. McRae, a cyst about 15 cm. in diameter and attached to the mesentery approximately 20 cm. proximal to the cecum was easily removed without damage to the mesenteric vessels.

The postoperative course was uneventful, and the patient was discharged on the seventh day of hospitalization.

The pathologic report, made by Dr. Daniel Leavitt, follows:

"The specimen consists of a large cyst measuring 12.5 by 8 by 7 cm. On cut sections there is a straw-colored fluid and some gelatinous material present. At one end of the cut section there are numerous small cysts containing a gelatinous substance. The largest cyst at the opposite end measures approximately 8 cm. in diameter.

"Microscopic Description: Section consists of a multiloculated cystic mass. The lumen contains amorphous eosinophilic matter and some blood. It is lined by a layer of flat nonspecific cells. Surrounding this is a layer of connective tissue infiltrated with scattered round cells, plasma cells, and a number of blood vessels. There is no evidence of malignancy.

"Diagnosis: Mesenteric cyst."

Discussion

These 2 cases of mesenteric cyst differ in several respects. In case 1 the growth was multiple, in case 2 single. In the former the adult male patient experienced gradual enlargement of the abdomen; in the latter the young Negro boy had a sudden manifestation of the abnormality. In both, the condition was asymptomatic until attention was focused on increasing size of the abdomen and on the presence of a tumor mass.

Case 1 indicates that lymphatic disease within the abdomen should be included in the differential diagnosis when gradual enlargement of the abdomen with no evidence of disease generally attributed to a massive neoplasm occurs in a man past the age of 40 years.

The laboratory studies, including roentgen examination, were in both instances of little help in formulating a diagnosis.

Summary

Two cases of intra-abdominal lymphangioma, one multiple and one single, with extirpation and uneventful recovery are reported.

Because the preoperative diagnosis of this type of tumor is seldom made, it is suggested that the index of suspicion toward the lymphatic system as a source of the growths be increased when the usual evidence of abdominal neoplasm is lacking and especially when there is an increase in abdominal girth not attributable to fluid or adipose tissue.

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225 West Ashley Street.

ABSTRACTS OF MEDICAL ARTICLES

CHEMOTHERAPY IN TUBERCULOSIS. By Hawley H. Seiler, M.D. International Record of Medicine 164 (Jan.) 1951.

Pointing out that the tubercle bacillus has been one of the last micro-organisms to yield before the onslaught of the newer antibacterial agents, this author discusses treatment with streptomycin, dihydrostreptomycin, para-aminosalicylic acid (PAS), and the newer drugs including tibione (TB-1), neomycin, mycomycin, terramycin, viomycin and diplomycin. Also discussed is the use of streptomycin in the treatment of extrapulmonary tuberculosis, notably miliary tuberculosis, tuberculous meningitis, and laryngeal and tracheobronchial tuberculosis.

It is concluded that the drug therapy of pulmonary tuberculosis at the present time in those cases in which it is indicated is probably best realized by the combined use of streptomycin and PAS for a period of ninety to one hundred and twenty days. Streptomycin in 1 Gm. dosage is given every third day and PAS, Gm. 12, is given daily. Sensitivity studies should be a coordinated part of any such regimen. Streptomycin is regarded as a valuable adjunct in thoracic surgery and useful in a number of extrapulmonary forms of tuberculosis. Dihydrostreptomycin is recommended when sensitization to streptomycin prohibits its use. Antibiotic therapy is advised only as a part of an integrated and long range plan of treatment with each case considered individually and on its own merits, for no drugs can as yet entirely supplant established methods of treatment.

CANCER OF THE BLADDER. By Louis M. Orr. American Surgeon 17:1 (Jan.) 1951; also Transactions of The South Eastern Section of The American Urological Association.

Dealing in broad generalizations rather than the usual statistical data, Dr. Orr reviews his impressions after personal experience with over 300 cancers of the bladder in a period of twenty-one years. The average age in the women of this series was 52.1 years and in men 61.1 years. He notes a general improvement in results year by year, which he attributes for the most part to improvement in adaptation of methods of therapy, and also in some degree to improvements in the basic technics in therapy.

He observes, however, that urologists are not seeing patients whose principal complaint is hematuria any sooner than they were twenty-five years ago, but these patients are seeing their family physicians earlier than in the past. Could it be, he asks, that urologists have become so provincial as a group that they have failed in stressing the significance of hematuria to their confreres in general medical practice?

Dr. Orr discusses the diagnosis and physical appearance of these tumors, also classification and treatment, both surgical and radiologic. He appeals unconditionally for more radical treatment in the earlier stages of the disease and for repeated warnings to the general medical profession on the early diagnosis of the cause of hematuria by urologists, which, in the final analysis, "depends upon mature, clinical judgment."

ACUTE HEMOLYTIC ANEMIA SECONDARY TO A HIGH TITER OF COLD AGGLUTININS IN A CASE OF PRIMARY ATYPICAL PNEUMONIA. By Joseph K. Freilich, M.D., and Louis Lemberg, M.D. Illinois M. J. 99:150-152 (March) 1951.

A case is reported in which acute hemolytic anemia developed secondary to an unusually high titre of cold agglutinins in a patient with primary atypical pneumonia. The literature is briefly reviewed and the current theory given for the cause of the hemolytic reaction. Repeated blood transfusions together with antibiotic therapy aided in the favorable outcome of the illness, which lasted three weeks.

It is suggested that acute hemolytic reactions should be watched for in the presence of high titres of cold agglutinins in acute febrile infectious diseases, especially in primary atypical pneumonia; that transfusions should be made with fresh blood, chilled blood being brought to room temperature; and that exposure and chilling of the patient, even from such causes as alcohol sponge baths, iced drinks or low temperature of oxygen tents, must be avoided. Routine determinations of the cold- agglutinin titre in these cases of primary atypical pneumonia are considered perhaps advisable in an attempt to prevent the development of this fairly serious complication.

PERMANENCE OF SO-CALLED TEMPORARY PHRENIC NERVE PARALYSIS. By Hawley H. Seiler and James D. Murphy. Am. Rev. Tuberc. 63:81-84 (Jan.) 1951.

A summary is presented of an analysis of 288 cases in which the patients in the course of treatment for pulmonary tuberculosis had been subjected to phreniclasia (335 operations) for temporary phrenic nerve paralysis. The purpose of the survey was to determine the permanence of the resulting paralysis. In approximately one half of the cases there was some degree of permanent paralysis, and in almost one fifth, total loss of diaphragmatic function, figures somewhat higher than those usually quoted. The authors observed that in terms of pulmonary functional disability, figures such as these must be weighed carefully when phreniclasia is being considered as a therapeutic procedure.

VITAMIN CONTENT OF CITRUS PRODUCTS. By W. A. Krehl and George R. Cowgill. Food Research 15:179-191 (May-June) 1950.

Since considerable information is available concerning the thiamine, niacin, pantothenic acid, carotene, and ascorbic acid content of citrus fruits and juices, this study was undertaken for the purpose of obtaining comprehensive data on the biotin, pyridoxine, folic acid, and inositol content of various citrus fruits, and evaluating the effects of processing and storage on these vitamins. It was made possible through a grant in aid provided by the Florida Citrus Commission and carried out at the Yale Nutrition Laboratory, Department of Physiological Chemistry, Yale University.

Samples of fresh and processed citrus juices, as nearly homogeneous as possible, withdrawn from a pooled composite sample representing a large number of boxes of citrus fruit in 17 Florida citrus processing plants, were assayed for their content of ascorbic acid, biotin, folic acid, pyridoxine, and inositol. Total solids and total acid were also determined. Although measurable quantities of biotin, folic acid, and pyridoxine were noted, these vitamins were present in only limited amounts in terms of practical nutritional significance. Ascorbic acid, as might be expected, was present in significant amounts and, in addition, the large amount of inositol present in the citrus products examined makes them a rich natural source of this vitamin.

VENTRICULAR ANEURYSM A CAUSE OF PERSISTENT RS-T SEGMENT DISPLACEMENT. By Elwyn Evans, M.D., F.A.C.P. Ann. Int. Med. 34:1048-1055 (April) 1951.

A case is reported in which, on the basis of a report in the literature of ventricular aneurysm associated with persistent RS-T segment displacement, a tentative diagnosis of an aneurysm of the ventricle was made in a patient showing striking persistent RS-T segment displacement following typical acute posterior myocardial infarction. This diagnosis was later confirmed at autopsy. It is concluded that ventricular aneurysm as a possible cause of persistent RS-T segment deviation in the electrocardiogram should be suspected if significant deviation persists.

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From Our President

Expanding Public Relations

Public relations activities of the Florida Medical Association have been intensified and broadened this year in an effort to carry the story of American Medicine to a segment of the population of the State of Florida, not reached previously.

At a meeting of the State Public Relations Committee in April, 1951, two new projects were added to the existing program, namely, Rural Educational Program, and Fair Exhibit.

The Rural Educational Program is sponsored jointly by the Florida Medical Association and the Florida Agricultural Extension Service of both State Universities. The latter, have well organized programs and are adequately staffed. The Florida Medical Association has agreed to provide these agencies with literature, films, transcribed radio programs on health, American Medical Association exhibits and the Florida Medical Association exhibit after the State Fair in Tampa, in February. Last, but not least, the Florida Medical Association has agreed to furnish speakers on health topics at the request of the Florida Agricultural Extension Service.

These speakers to be most effective should come from the local community. The request for a speaker is usually made by the Agency through the Chairman of the Public Relations Committee, Dr. Eugene B. Maxwell. It is possible that one of the county agents may contact the local county medical society direct. The success of this important project depends on the response and cooperation of the individual members of the State Medical Association. Let me urge you to assist in making this program a success, and when called on to make every effort to participate.

The program is in its infancy. To date the response of the membership to Dr. Maxwell's requests have been enthusiastic. An increase in calls for speakers is anticipated in the near future as the program develops. We have an invitation to carry the story of American Medicine to a large segment of the population by personal contact. Make the most of this opportunity.

David R. Murphy Jr

The Journal of the Florida Medical Association

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The Gift of Giving

Gracious giving partakes of the art of living. It is a gift within itself. Certainly it is part and parcel of the art of practicing medicine. What physician does not know that a kindly word, a bit of cheer, a clasp of the hand, a pat on the shoulder, may mean more than riches? The extent to which the doctor gives — of self — is in a real sense the measure of his professional success.

As December brings again the season of special giving, it is well to reflect that neither talent nor money in large amounts is requisite to true giving. The many worthy causes need not only our money but ourselves. The best present is tied with the heart strings; it bespeaks the depth and sincerity of emotional response. Too, it is spontaneous giving that often proves to be the most successful gift.

The professional man, the business man, the man with a hobby, in fact, every man has gift opportunities peculiar to himself. Especially is it true of the physician that the door of opportunity is wide open in this respect. Daily the practitioner of medicine who is true to his calling expends himself wholeheartedly in the pursuit of his profession. Now he is further committed, and as never before, to the expenditure of self in the forefront of the battle to preserve the American way of life.

The doctor does not need the holiday season to remind him that the giving of self knows no special days. Every day offers the opportunity — to him and to all — to give of self to someone who needs the uplift of such giving. It was Emerson who expressed the essence of true giving when he wrote, "The only gift is a portion of thyself."

December Anniversaries

December 4 and 25. The first publication concerning antitoxins was that of Emil von Behring on Dec. 4, 1890, in which he reported his experiments in guinea pigs with antitoxins for tetanus and diphtheria. On Christmas day, the following year, Behring's diphtheria antitoxin was first administered to human beings. It is hardly necessary to remark upon the striking change in incidence and degree of severity the disease has undergone during the sixty years which have elapsed since that date. The work takes on even more significance when one reflects that even in this modern age of chemotherapy and antibiotics, no other agent has been found which will adequately control the disease.

December 10. Josef Skoda of Vienna was born on Dec. 10, 1805. He was the son of a locksmith of Pilsen in Bohemia, who had no funds



Courtesy, Willius: A History of the Heart and the Circulation, Philadelphia, W. B. Saunders Company.

for his medical education. Except for the generosity of a friend, Josef would have abandoned a medical career for the monastic habit. When 20 years of age, he walked to Vienna, a six days' journey by foot, to begin his studies at the University which he later helped to make world-famous. By tutoring in physics and mathematics to pay his way, he acquired knowledge in the fundamental sciences which later on aided greatly in his phenomenal achievements. So proficient was he in mathematics that his professor urged him to abandon medicine.

Not long after graduation, he obtained a subordinate position in the Allgemeines Krankenhaus. When the French minister to Austria lay ill with a disease diagnosed by three leading physicians of Vienna as hepatic disease, Skoda was called into consultation. Young as he was, he made the first clinical diagnosis of aneurysm of the abdominal aorta, which was confirmed at death soon afterward. It was then that his old professor remarked, "If I were younger, I'd go to school to you."

Impressed by the studies of Auenbrugger on percussion and of Laennec on auscultation, he developed the inductive method in medicine through which conclusions are based on well known physical laws rather than on superficial observations and guesswork. Above all, he devoted his studies to the auscultation of the heart, conducting his bedside investigations with such zeal that his patients accused him of "mauling them about." Soon there flocked to his lectures the older professors and those from abroad, all eager to learn the mysteries of auscultation and percussion.

In 1839 Skoda published his famous monograph, "Abhandlung über Percussion und Auskultation," which passed through many editions and was translated into many languages. It forms the scientific basis of modern physical diagnosis. His views met with strong opposition in his own school, but were brilliantly confirmed through the following century and remain today a valuable part of the treasure of practical medicine.

Described as "a man of genius in the rapidity and acuity of his observations and in the rigour of his criticism," this skilled diagnostician of complicated diseases served for a quarter of a century as professor of clinical medicine at his alma mater. In 1875, six years before his death, he was given appropriate acclaim by all the bodies of learned men in Vienna, and a gold medal was struck to commemorate the event.

DECEMBER 11. Robert Koch of Göttingen and Berlin, born on Dec. 11, 1843, shares with Pasteur the honor of founding the science of bacteriology. Koch developed the science from the medical standpoint while Pasteur was interested in the chemical approach.

Koch's discovery of the method of isolating micro-organisms on solid mediums made the study of bacteriology much more practical while his isolation of the tubercle bacillus and introduction of tuberculin established his fame. Most every medical student today learns to recite Koch's postulates.

Numerous pupils from many countries who crowded his clinic, reported Koch to be an inspiring teacher. He was awarded the Nobel Prize in 1905.

DECEMBER 15. Philip Syng Physick of Philadelphia, who was born on July 7, 1768 and died on Dec. 15, 1837, is often called the Father of American Surgery. After excellent training in London and Edinburgh, he began practice in Philadelphia, where he experienced several lean years despite his exceptional training. Conscientious service during the severe epidemic of yellow fever in 1793, however, brought him renown, and his careful surgical technic during that early era apparently was responsible for his appointment

in 1805 as the first professor of surgery at the University of Pennsylvania. Thus he held the first chair of surgery in America which was divorced from the sister subject, anatomy.

This early American surgeon is credited with several surgical innovations. He was the first to invent a tonsillotome, and he devised a new iridectome, a genitourinary operation and the operation for artificial anus. He was a pioneer in the use of absorbable ligatures and the first after Monro (Secundus) to use the stomach pump. His most famous operation was the successful removal of several hundred stones from the bladder of Chief Justice Marshall. His one outstanding error was his sincere belief, shared by Benjamin Rush and other prominent physicians of that day, that copious bleeding was beneficial in the treatment of disease.

In manner Dr. Physick was dignified, kindly and sometimes melancholy. The precautions he took to prevent his being buried alive, or his body being stolen for anatomic dissection, apparently were the result of an experience the night after the funeral of Dr. Rush. A burly Negro is said to have rung his door bell and inquired, "Do you want Dr. Rush? I will have him at the College for you at nine o'clock tomorrow morning for twenty dollars."



363. *Philip Syng Physick,*
"the Father of American Surgery."
(From the original portrait by Sully at the UNIVERSITY OF PENNSYLVANIA.)

Legion Survey of Health Resources

Secretaries of state and county medical societies are requested to cooperate with representatives of the National Rehabilitation Commission of The American Legion, which is currently conducting a national survey of "hospital beds for veterans and health resources." Basic studies for this survey have already been completed in several states, and Legion representatives are now engaged in collecting pertinent facts and figures throughout the country. Dr. Leonard G. Roundtree, chief medical advisor for the Legion, has given assurance that "all reports before release will be passed on for review to the American Medical Association, its state societies, and the Veterans Administration and its departments."

This national survey is being carried out in compliance with a resolution passed by the Legion in November 1950, which called for a survey of "facts and figures on veterans hospitalization needs, additional hospital beds, medical manpower shortage and medical teaching institutions throughout the country."

"The American Legion strongly advocates," the resolution also stated, "that medical schools of this country produce more doctors without sacrifice of quality; expansion within the existing schools of medicine to maximum capacity compatible to efficiency; expansion of courses to four years wherever possible, and creation of new medical schools sponsored by colleges or universities where needed and where proper support is assured."

Frozen Orange Juice Concentrate

Reflecting the changing food habits of a nutrition-conscious public, the increased consumption of orange juice in both the fresh and frozen forms is of particular interest in Florida. Although it was introduced only four years ago, frozen concentrated orange juice now accounts for some 35 per cent of all frozen food sales, exclusive of ice cream. This finding of the Council on Foods and Nutrition of the American Medical Association led it to consider this product of sufficient public health importance to warrant a report.[1]

The Council concluded that frozen concentrated orange juice made from properly selected and prepared fruit is a dependable source of vitamin C and that it may be useful in the diets of persons of all ages. In fact, its report states, it is reliably estimated that approximately 98 per cent of the vitamin C content of the fresh fruit may

be retained in the frozen concentrated juice when modern acceptable methods are used. Also, when it is held in storage at the freezing point or below, there is practically no loss of vitamin C. The flavor, too, in general is excellent, and although the color may vary appreciably, the variation has no effect on the vitamin C content.

Evidence submitted to the Council indicates that concentrated frozen orange juice may be used in all instances wherein there is need for maintaining or increasing the daily intake of vitamin C. It may, indeed, be considered as "the nutritive equal of fresh orange juice." It will thus meet the need for vitamin C intake in the diets of all persons, including infants.

Among the important studies of citrus products currently being reported in the literature, one by Krehl and Cowgill[2] from the Yale Nutrition Laboratory recently established that biotin, folic acid, and pyridoxine are present in fresh and processed citrus juices in limited amounts in terms of practical nutritional significance. These investigators found, however, that ascorbic acid, as might be expected, was present in significant amounts in samples withdrawn from a pooled composite sample representing a large number of boxes of citrus fruit in seventeen Florida citrus processing plants, and that the large amount of inositol present in the citrus products examined makes them a rich natural source of this vitamin.

1. Council on Foods and Nutrition: Frozen Orange Juice Concentrate, J. A. M. A. 146:35 (May 5) 1951.
2. Krehl, W. A., and Cowgill, G. R.: Vitamin Content of Citrus Products, Food Research 15:179-191 (May-June) 1950.

Medical Service to Military Personnel Abroad

Recently, "Today's Health" carried an interesting account by Dr. Elmer L. Henderson, immediate past president of the American Medical Association, of his trip to the Far East and to Europe as a consultant to the United States Air Force. He found the soldiers everywhere abroad receiving excellent medical attention.

Dr. Henderson was particularly impressed by his observation that "none of the hospitals is overstaffed as they were during the last war." He talked with many physicians in both theaters and found them satisfied that they are doing "a worthwhile job." It was plain to him that the situation, so far as morale of medical personnel is concerned, is much improved over World War II.

At Wiesbaden, Germany, known as the "Air Force Capital of Europe," Dr. Henderson found the hospital providing medical aid and hospitalization for a sizeable community of dependents of military personnel in addition to members of the Army, Air Force and Navy. It also serves squadrons and camps all over Europe.

From that strategic medical center he brought back a message from a Florida physician. "At the Wiesbaden hospital," writes Dr. Henderson, "I talked with 1st Lt. Frank D. Howard, 26-year-old physician from Leesburg, Fla., who was called to active duty last January. Lt. Howard, who graduated from the University of Tennessee Medical School and took his training at Lloyd Nolan Hospital at Fairfield, Ala., arrived at Wiesbaden last February. Most of his work is in the field of urology.

" 'I have been pleasantly surprised with the type of assignment here,' Lt. Howard told me, adding that he felt the Air Force had been very thoughtful of 'my professional desires within the limits of medical activity possible, considering the ages in the service.' "

American Laryngological, Rhinological and Otological Society Southern Section Meeting

The Southern Section of the American Laryngological, Rhinological and Otological Society will meet in Atlanta, Ga., at the Academy of Medicine on Monday, Jan. 14, 1952. This will be a one day meeting, and there will be six speakers, each of whom is pre-eminent in his field:

Dr. John E. Bordley, Baltimore, "The Problem of the Preschool Deaf Child: The Otologist's Role in Diagnosing His Deafness and Supervising His Rehabilitation;" Dr. Samuel L. Fox, Baltimore, "Bleeding Following Tonsillectomy;" Dr. V. K. Hart and Dr. William Pitts (neurosurgeon, by invitation), Charlotte, N. C., "The Diagnosis and Treatment of Acute Subdural Abscess Secondary to Frontal Sinusitis;" Dr. Julius W. McCall, Cleveland, "Cancer of the Larnyx;" Dr. Harry Rosenwasser, New York, "Glomus Jugularis Tumor of the Middle Ear" (author of the first clinical article on this subject); and Dr. Joseph A. Sullivan, Toronto, Canada, "Recent Advances in the Treatment of Facial Paralysis and Bell's Palsy."

All members of the medical profession are cordially invited to this meeting. There is no registration fee.

Midwinter Seminar in Ophthalmology and Otolaryngology

The sixth annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will convene on Jan. 14, 1952 and continue through January 19. As in previous years, Miami Beach will be the host city, and this year the Sans Souci Hotel will be headquarters.

The lectures on Ophthalmology will be presented on January 14, 15 and 16; those on Otolaryngology on January 17, 18 and 19. Lecturers for the courses in Ophthalmology will include such distinguished medical teachers as Dr. Alson E. Braley, Iowa City, Iowa; Dr. John M. McLean, New York City; Dr. Wendell Hughes, Hempstead, N. Y.; Dr. Irving H. Leopold, Philadelphia, and Dr. Bruce Fralick, Ann Arbor, Mich. Outstanding Otolaryngologists who will lecture include Dr. Fred W. Dixon, Cleveland; Dr. Thomas D. Galloway, Evanston, Ill.; Dr. Anderson G. Hilding, Duluth, Minn.; Dr. Moses H. Lurie, Boston, and Dr. Henry L. Williams, Rochester, Minn.

On Wednesday evening, January 16, all registrants are cordially invited to attend the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology, which meets concurrently with the Seminar. Distinguished speakers will address this gathering.

The Southern Section of the American Laryngological, Rhinological and Otological Society will meet on Monday, January 14, in Atlanta, Ga. The Pan-American Congress of Oto-Rhino-Laryngology and Broncho-Esophagoly planned its meeting in Havana the week following the Seminar. Registrants of the Seminar may desire to attend these meetings also.

Dr. Cline Speaks in Miami

Dr. John W. Cline of San Francisco, president of the American Medical Association, spent a busy weekend in Miami the first week in October. He was the principal speaker at the second annual meeting of the Florida Medical Committee for Better Government, which was attended by several hundred Florida physicians and their wives. This pioneer organization, like similar groups in California, Maryland and a few other states, functions apart from any organized county, state or national medical society, is entirely nonpartisan and nonprofit, and seeks to promote more interest and participation in government on the part of physicians.

In a public address in Miami's Bayfront Park auditorium on October 7, Dr. Cline discussed "American Medicine Accents the Positive." He declared that government control over the American medical system, in one form or another, again probably will become a live political issue in 1952. "And once again," he commented, "it will be only one manifestation of the broad issue of state socialism." He warned that "government-controlled medicine would be only the first big step toward destruction of the American system of free enterprise, the first big feather in the cap of the socializers." Also, he promised that "the doctors of America will be vigilant, ready and active," adding, "And I hope and believe that the entire American public, regardless of party affiliations, will be likewise."

At a luncheon meeting of the committee, he stressed the importance of good public relations. Publicly and privately, in addresses and in conferences with the press and medical groups, he set forth clearly that "the ultimate objective of the American Medical Association is to make low cost, adequate protection available on a sound medical and financial basis to every American who needs it and wishes it."

Medical District Meetings, 1951

Association members had an opportunity at the four medical district meetings October 22-26 to meet their state officers and learn from them about important state level activities. At the same time those attending were treated to two informational scientific papers at each meeting.

Dr. William C. Roberts, chairman of the Council, presided at both the scientific assembly and the general session of each of the four meetings. In each instance he was ably assisted by councilors from the respective districts. All eight councilors were in attendance, but Dr. Eugene L. Jewett, councilor of District 3, was prevented from presiding by an emergency call.

Dr. David R. Murphey, Jr., President, inspiringly addressed each of the groups on the "American Medical Education Foundation."

Dr. Samuel M. Day, Secretary-Treasurer, selected "Blue Shield" as his subject and ably described the current status of this offspring of the Association.

Dr. Shaler Richardson, Editor of the Journal, explained the various activities necessary to produce a scientific journal which compares favorably with others in its field.

At each of the meetings, Dr. J. Rocher Chappell, Chairman of the State Committee on Advisory to Selective Service for Physicians and Allied Specialists, reviewed current information on this subject. Dr. Chappell emphasized that all such committees, whether on state or county level, had received confirmation by the Federal government and therefore proposed changes in personnel must be submitted to the proper authorities through approved channels.

Dr. Eugene B. Maxwell, Chairman of the Association's Committee on Public Relations, outlined the program formulated by his committee. Dr. Maxwell explained that processing the program is facilitated greatly by assistance from the Bureau of Public Relations. Dr. Maxwell's talk was presented immediately following the dinner in the evening. Jointly appearing with Dr. Maxwell at the Pensacola, Bradenton-Sarasota and Vero Beach meetings was Mrs. James L. Anderson, chairman of the Public Relations committee of the Woman's Auxiliary to the Florida Medical Association. At the Orlando meeting this spot on the evening program was filled by Mrs. C. Robert DeArmas, President of the Auxiliary.

Northwest Medical District — A
October 22 — Pensacola

Dr. Benjamin J. Wilkinson, councilor of District 2, presided with Dr. Roberts at the scientific assembly, with Dr. Arthur J. Butt, councilor of District 1, assisting at the general session.

Dr. Lee Sharp, president of the Escambia County Medical Society, welcomed members and guests as the meeting opened at 2:30 p.m.

Immediately following, Dr. Joseph W. Douglas of Pensacola presented a paper on "Gynecological Causes of Pelvic Pain." Dr. William F. Humphreys, Jr., of Panama City then spoke on "Common Pediatric Emergencies." A general discussion followed the reading of the papers.

Panama City was selected as the meeting place for 1952.

Officers and Committeemen of the State Association presented short talks on matters of concern to all members of the Association. In addition to the talks referred to above which were given at all four meetings, Dr. Julius C. Davis of Quincy spoke on behalf of gifts to the American Medical Education Foundation. Dr. George W. Morse of Pensacola discussed the Cancer Council; Dr. Joseph W. Douglas of Pensacola, Maternal and Child Welfare; and Dr. Francis T. Holland of Tallahassee urged doctors to join the Florida Medical Committee for Better Government and explained that this is not a committee of the Florida Medical Association. "It is entirely non-profit and nonpartisan. It is permanent and state-wide in scope, organized completely independent of organized medicine at national, state and county levels. It is open for membership to every licensed doctor of medicine (M.D.) in the state of Florida."

Refreshments and dinner were served by the host society with Dr. William C. Roberts of Panama City acting as toastmaster.

The total registered was 76, of which 49 were Association members (from A district, 41), 2 visitors and 25 Woman's Auxiliary. State Association officers present were: David R. Murphey, Jr., president; Robert B. McIver, president-elect; Samuel M. Day, secretary-treasurer and Stewart G. Thompson, managing director. Committee chairmen present were: Eugene B. Maxwell, Public Relations; J. Rocher Chappell, Advisory to Selective Service for Physicians and Allied Specialists; Julius C. Davis, Medical Education and Hospitals; Alvin L. Stebbins, Tuberculosis and Public Health; Egbert V. Anderson, Child Health; Walter C. Payne, Grievance; William C. Roberts, chairman of Council; Arthur J. Butt, councilor of District 1 and Benjamin C. Wilkinson, councilor of District 2. Past presidents of the Florida Medical Association in attendance included Julius C. Davis, Walter C. Payne, Herbert L. Bryans and Shaler Richardson.

Registration

CANTONMENT: Stanley G. Childers. JACKSONVILLE: Samuel M. Day, Robert B. McIver, Shaler Richardson, Wilson T. Sowder, Stewart Thompson. MARIANNA: Francis M. Watson. ORLANDO: J. Rocher Chappell. PANAMA CITY: William F. Humphreys, Jr., William C. Roberts. PENSACOLA: Allen M. Ames, Egbert V. Anderson, Bernard M. Barrett, Pascal G. Batson, Jr., Alan E. Bell, John D. Bell, Arthur J. Butt, Herbert L. Bryans, Joseph W. Douglas, Charles W. Duval, Harry B. Haisfield, Henry O. Heath, William P. Hixon, Frank B. Hodnette, Alpheus T. Kennedy, Sidney G. Kennedy, Jr., Mozart A. Lischkoff, John J. McGuire, John C. McSween, Jr., Noel C. Mellen, George W. Morse, Walter C. Payne, Samuel B. D. Rhea, Nathan S. Rubin, Lee Sharp, Mary R. S. Stauffer, Alvin L. Stebbins, Rosa L. Sullivay, Carol C. Webb, Alvyn W. White, Edward T. White, Jr., William L. Williams, Dale E. York. PORT ST. JOE: John W. Hendrix. QUINCY: Julius C. Davis. TALLAHASSEE: Francis T. Holland, Benjamin A. Wilkinson. TAMPA: Eugene B. Maxwell, David R. Murphey, Jr.

VISITING DOCTORS—CHIPLEY: Frederick B. Jones.

OTHER GUESTS — JACKSONVILLE: Mr. Tom Jarvis.

Southwest Medical District — C
October 24 — Bradenton-Sarasota

Dr. Hugh G. Reaves, councilor of District 5, assisted Dr. Roberts in presiding at the scientific assembly; and Dr. Leldon W. Martin, councilor of District 6, presided with Dr. Roberts at the general session.

Dr. Sherrell D. Patton, president of the Sarasota County Medical Society, welcomed the members and guests.

Dr. Donald W. Hedrick of Tampa opened the scientific program with his papers on "Management of Acute Extremity Injuries" and "Preventive Orthopedics in the Teen Ages." Dr. Eugene D. Liddy, Jr., of Sarasota spoke on "Pitfalls in Modern Therapy." A discussion followed.

At the general session, St. Petersburg was designated as the meeting place for 1952.

Addresses of statewide interest were presented by Officers and Committeemen of the State Association. Dr. Chadbourne A. Andrews of Tampa, a member of the Council of the Southern Medical Association, gave a short talk. Dr. Hugh G. Reaves of Sarasota discussed the Cancer Council, and Dr. Francis H. Langley of St. Petersburg urged doctors to join the Florida Medical Committee for Better Government and explained that this is not a committee of the Florida Medical Association. "It is entirely non-profit and nonpartisan. It is permanent and state-wide in scope, organized completely independent of organized medicine at national, state and county levels. It is open for membership to every licensed doctor of medicine (M.D.) in the state of Florida."

Refreshments and dinner were served by the host societies, with Dr. Joseph Halton of Sarasota acting as toastmaster.

The total registration was 125, of which 77 were Association members (from C district, 70), 10 visitors and 38 Woman's Auxiliary. State Association officers present were: David R. Murphey, Jr., president; Robert B. McIver, president-elect; Samuel M. Day, secretary-treasurer; Shaler Richardson, editor of The Journal and Stewart Thompson, managing director. Committee chairmen present were: Eugene B. Maxwell, Public Relations; J. Rocher Chappell, Advisory to Selective Service for Physicians and Allied Specialists; Joseph Halton, Necrology; William C. Roberts, chairman of Council; Hugh G. Reaves, councilor of District 5 and Leldon W. Martin, councilor of District 6. A past president of the Florida Medical Association in attendance was Shaler Richardson.

Registration

ARCADIA: Henry P. Bevis, Gordon H. McSwain. BARTOW: Milo H. Holden. BRADENTON: Lowrie W. Blake, John E. Granade, Willis W. Harris, Roderic O. Jones, Millard P. Quillian, William D. Sugg, Binford Throne, Marjorie L. Warner, Willett E. Wentzel. CLEARWATER: Percy H. Guinand, William G. Mason. DUNEDIN: John A. Mease, Jr., Walter H. Winchester. FT. MYERS: William H. Grace, H. Quillian Jones, Joseph L. Selden, Jr. JACKSONVILLE: Samuel M. Day, Robert B. McIver, Shaler Richardson, Wilson T. Sowder, Stewart Thompson. MANATEE: Blake M. Lancaster. ORLANDO: J. Rocher Chappell. PAHOKEE: Chas. E. Creel. PANAMA CITY: William C. Roberts. PLANT CITY: Madison R. Pope. PUNTA GORDA: Walter B. Clement. ST. PETERSBURG: William M. Davis, James L. Gouaux, Francis H. Langley, Harrison G. Palmer, John P. Rowell, Benjamin H. Sullivan, Paul F. Wallace. SARASOTA: Thomas C. Garrett, Joseph Halton, J. Edward Harris, Harold T. Lawler, Eugene D. Liddy, Jr., A. Lamar Matthews, Jr., A. George Meister, Arthur O. Morton, John C. Patterson, Sherrel D. Patton, Robert O. Pitts, Hugh G. Reaves, Karl R. Rolls, Melvin M. Simmons, Walker E. Swift, Thomas W. Taylor, Theodore M. Trousdale, Millard B. White, Reaves A. Wilson, Thomas R. Young, Jr. SEBRING: Leldon W. Martin, Zaven M. Seron. TAMPA: Chadbourne A. Andrews, Ernest R. Bourkard, Leffie M. Carlton, Jr., Herschel G. Cole, J. Brown Farrior, Chas. McC. Gray, H. Phillip Hampton, Donald W. Hedrick, Eugene B. Maxwell, David R. Murphey, Jr., Wade C. Myers, Jr., Robert H. Owrey, Hawley H. Seiler, Burdette Smith, Marshall E. Smith, Elbert J. Soskis, William W. Trice, Jr., Wesley W. Wilson.

VISITING DOCTORS — BRADENTON: S. J. Hillis. DUNEDIN: James O. Norton. JACKSONVILLE: Knox E. Miller. MANATEE: Frederick N. Williams. SARASOTA: Harry E. Sharrer. TAMPA: Rosalind E. Ebersbach, J. M. Ingram, Jr., Thomas E. McKell, George J. Suarez.

OTHER GUESTS — JACKSONVILLE: Mr. Tom Jarvis.

Southeast Medical District — D
October 25 — Vero Beach

Presiding with Dr. Roberts at the scientific assembly was Dr. Donald W. Smith, councilor of District 8. Dr. Adrian M. Sample, councilor of District 7, assisted Dr. Roberts in presiding at the general session.

Members and guests were welcomed by Dr. Erasmus B. Hardee, president of the Indian River County Medical Society.

Dr. Marvin G. Flannery of Miami presented a scientific paper on "Surgical Treatment of Ulcerative Colitis." Dr. Scottie J. Wilson of Fort Lauderdale then spoke on "The Hazards of Hormone Therapy." Discussion of the papers followed.

Fort Pierce was chosen as the meeting place for 1952.

Officers and Committeemen of the State Association presented talks of interest to all members. Dr. Wilson T. Sowder of Jacksonville made a few remarks.

Refreshments and dinner were served by the host society with Dr. Erasmus B. Hardee of Vero Beach as toastmaster.

The total registration was 72, of which 39 were Association members (from D district, 30), 6 visitors and 27 Woman's Auxiliary. State Association officers present were: David R. Murphey, Jr., president; Robert B. McIver, president-elect; Samuel M. Day, secretary-treasurer; Shaler Richardson, editor of The Journal and Stewart Thompson, managing director. Committee chairmen present were: Eugene B. Maxwell, Public Relations; J. Rocher Chappell, Advisory to Selective Service for Physicians and Allied Specialists; John D. Milton, Board of Governor's sub-committee on the Review of Fee Schedules; William C. Roberts, chairman of Council; Adrian M. Sample, councilor of District 7 and Donald W. Smith, councilor of District 8. Past presidents of the Florida Medical Association in attendance were Homer L. Pearson, Jr. and Shaler Richardson.

Registration

DANIA: Fred E. Brammer. FT. LAUDERDALE: William A. Exum, M. Austin Lovejoy, Scottie J. Wilson. FT. PIERCE: Henry E. Branca, Hugh B. Goodwin, Jr., Francis A. Gowdy, John T. McDermid, Adrian M. Sample. JACKSONVILLE: Samuel M. Day, Robert B. McIver, Shaler Richardson, Wilson T. Sowder, Stewart Thompson. MIAMI: Reuben B. Chrisman, Jr., Joseph H. Crawley, Marvin G. Flannery, Carlos P. Lamar, John D. Milton, Homer L. Pearson, Jr., Donald W. Smith, George Williams, Jr. OKEECHOBEE: Leon S. Eisenman. ORLANDO: J. Rocher Chappell. PALM BEACH: Russell D. D. Hoover. PANAMA CITY: William C. Roberts. STUART: Julian D. Parker. TAMPA: Eugene B. Maxwell, David R. Murphey, Jr. VERO BEACH: William L. Fitts, 3rd, John P. Gifford, Erasmus B. Hardee, P. T. McClellan, James C. Robertson. WEST PALM BEACH: Charles McD. Harris, Jr., Lloyd J. Netto, S. Richard Ombres, Ralph M. Overstreet, Jr., Murray D. Sigman.

VISITING DOCTORS — HOLLYWOOD: Ben Rosner. VERO BEACH: John E. Burt, Kip G. Kelso, Leo Sheiber. WEST PALM BEACH: Richard M. Irwin.

OTHER GUESTS — JACKSONVILLE: Mr. Tom Jarvis.

Northeast Medical District — B

October 26 — Orlando

The meeting was held at the Orange Court Hotel with Dr. Eugene G. Peek, Jr., councilor of District 3, presiding with Dr. Roberts.

At 2:30 p.m., members and guests were welcomed by Dr. Fred Mathers, president of the Orange County Medical Society.

The scientific program was opened by Dr. Herbert A. King of Daytona Beach who presented a paper on "Common Hematological Problems and Their Interest." Dr. John J. Cheleden of Ocala spoke on "Proctologic Problems of Interest to the General Practitioner." The floor was opened for discussion of the papers.

At the general session, Daytona Beach was selected as the meeting place for 1952.

Short talks of statewide interest were presented by Officers and Committeemen of the State Association. Dr. Ashbel C. Williams of Jacksonville spoke on the Cancer Council, and Dr. Dorothy D. Brame discussed Maternal and Child Welfare.

Refreshments and an outdoor barbecue were provided by the host society.

The total registration was 106, of which 88 were Association members (from B district, 85), 14 visitors and 4 Woman's Auxiliary. State Association officers present were: David R. Murphey, Jr., president; Robert B. McIver, president-elect; Samuel M. Day, secretary-treasurer; Shaler Richardson, editor of The Journal and Stewart Thompson, managing director. Committee Chairmen present were: Eugene B. Maxwell, Public Relations; J. Rocher Chappell, Advisory to Selective Service for Physicians and Allied Specialists; Eugene G. Peek, Sr., Legislation and Public Policy; C. Robert DeArmas, Advisory to Woman's Auxiliary; William C. Roberts, chairman of Council; Eugene G. Peek, Jr., councilor of District 3 and Eugene L. Jewett, councilor of District 4. Past presidents of the Florida Medical Association in attendance included Eugene G. Peek, Sr., John S. McEwan, Herbert E. White, Shaler Richardson, and William C. Thomas, Sr.

Registration

APOPKA: Thomas E. McBride. COCOA: A. F. Thomas. DAYTONA BEACH: James W. Clower, Jr., C. Robert DeArmas, David W. Goddard, Herbert A. King, Alphonsus M. McCarthy, George H. McSwain, James D. Moffett, Jr., Achille A. Monaco, Norman E. Williams. DELAND: Lancaster C. Starke (col.). EUSTIS: Matthew Arnow, R. H. Williams. GAINESVILLE: Edwin H. Andrews, Henry H. Graham, John E. Maines, Jr., William C. Thomas, Sr. HOLLY HILL: Frank A. Sica. JACKSONVILLE: George A. Dame, Samuel M. Day, James G. Lyerly, Robert B. McIver, Thaddeus M. Moseley, III, Shaler Richardson, Wilson T. Sowder, Stewart Thompson, Edward C. Watt, Ashbel C. Williams. LEESBURG: George E. Engelhard, Marion B. O'Kelley, H. Durham Young, Jr. MELBOURNE: Arthur C. Tedford. MOUNT DORA: Glendy G. Sadler. OCALA: William H. Anderson, Jr., John J. Cheleden, Carl S. Lytle, Eugene G. Peek, Sr., Eugene G. Peek, Jr., William H. Turnley. ORLANDO: Clarence Bernstein, Frank C. Bone, Dorothy D. Brame, Thomas C. Butt, Robert A. Broome, Jr., Marion S. Brown, J. Rocher Chappell, Benjamin M. Cole, Chas. J. Collins, Norman F. Coulter, Robert W. Curry, Leland H. Dame, Horace A. Day, Russell V. Douglas, Elwyn Evans, L. Paul Foster, Frank D. Gray, I. Sylvester Hankins (col.), Robert P. Henderson, Eugene L. Jewett, Hewitt Johnston, Morris H. R. Lukens, Duncan T. McEwan, John S. McEwan, J. William Martin, Fred Mathers, Alexander P. Maybarduk, John P. Michaels, William S. Mitchell, Robert G. Neill, Don C. Robertson, W. Dean Steward, Robert L. Tolle, A. Fred Turner, Jr., Robert W. Young. PALATKA: Grover C. Collins. PANAMA CITY: William C. Roberts. ST. AUGUSTINE: Herbert E. White. ST. CLOUD: James C. Rinaman. SANFORD: Orville L. Barks, Edwin Epstein, Thomas F. McDaniel, Charles L. Park, Harry Z. Silsby, George H. Starke (col.). TAMPA: Eugene B. Maxwell, David R. Murphey, Jr. WINTER GARDEN: Albert H. Gleason.

VISITING DOCTORS — DAYTONA BEACH: Y. O'Donnell. JACKSONVILLE: H. L. Brie, Knox E. Miller, Charles H. Parent. MAITLAND: Fred L. Adair. ORLANDO: Rex M. Bleakney, Richard C. Hartsfield, Ian MacDonald, James D. Moody, R. A. J. Morby, John E. Startzman.

CALIFORNIA — SAN DIEGO: Gordon D. Skeoch.

HAWAII — HONOLULU: William H. Wynn.

OTHER GUESTS — JACKSONVILLE: Mr. Tom Jarvis.

YOUR BLUE SHIELD

Blue Shield-Blue Cross Non-Group Enrolment

Since so many Blue Shield physicians have expressed interest in the new non-group enrolment program, undoubtedly they will be interested in the results of the first announcement to the general public.

The announcement to the public was made in the second week of October through ads placed in eight newspapers in metropolitan areas in the State. The response to this first announcement exceeded all expectations.

Included in the ad was a coupon to be sent to Blue Shield-Blue Cross for a non-group application form and complete details about enroling. Within two weeks time and from only eight newspaper ads, 5,370 coupons had been received. All requests were promptly filled and 8 per cent of all applications sent out were returned within two weeks.

Response to the announcement was greater in the more densely populated areas of the state. You might be interested in a break-down of the number of inquiries and requests received by city during the first two weeks following the announcement.

Cities	Requests Received
Miami	1,336
Orlando	708
Jacksonville	467
St. Petersburg	317
Tampa	248

The second, or follow-up ad, also was run in eight daily newspapers during the second week of November, however, at the time of the writing of this article the response was not known.

In addition to requests received from the newspaper advertisement, inquiries and requests for applications and literature have poured in from all parts of the State after distribution of non-group inquiry forms by Blue Shield physicians and Blue Cross hospitals. Blue Shield physicians have been most active and cooperative in promoting this new enrolment program.

Additional supplies of non-group material will be sent to any Blue Shield physician upon request addressed to Blue Shield-Blue Cross, 532 Riverside Avenue, Jacksonville, Florida.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Samuel R. Lamb of Jacksonville announce the birth of a daughter, Kathleen Elizabeth, on October 10.

Dr. and Mrs. Julian M. DuRant of Madison announce the birth of a son, Frank Harrison, on October 17.

Deaths — Members

Chiles, Joseph H., Orlando ..... Aug. 6, 1951
Turberville, Joe I., Century ..... Oct. 20, 1951
Turberville, John K., Century ..... Nov. 1, 1951

Deaths — Other Doctors

Page, Landrum J., Fayetteville, N. C. ..... July 6, 1944
Thach, Andrew B., Nashville, Tenn. ..... July 27, 1951
Hoffman, Clifford W., Lake City ..... Oct. 2, 1951
Tompkins, Raymond D., Sebring ..... Recently

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Brown, Robert J., Jacksonville
Cassiday, Francis P., Pensacola
Chaplin, Charles G., Jacksonville
Davis, Joseph B., Daytona Beach
Douglas, Robert H., Tampa
Ebersbach, Rosalind E., Tampa
English, Alvin Q., Palmetto
Forthman, Wm. H., Miami
Frame, Eugene M., Jacksonville
Franklin, Ben T., Sr., Jacksonville
Gillespie, Elmer H., Clearwater
Howell, L. M., Jacksonville
Hutchison, William C., Miami
Kaminski, Bernard A., Miami
McDowell, Richard W., Jacksonville
Moseley, Thaddeus M., III, Jacksonville
Morse, Seymour, Jacksonville
Nevel, Harry A., Jacksonville
Nixon, Donald H., Miami
Pate, Julien C., Jr., Tampa
Ritch, Thomas G., Jacksonville
Skinner, Richard G., Jr., Jacksonville
Stubbs, George M., Jacksonville
Toto, Lawrence A., Miami Shores
Wallace, Paul F., St. Petersburg

STATE NEWS ITEMS

Mr. Norman J. Ulbright of University City, Mo., will assume the post of Acting Supervisor of the Florida Medical Association Bureau of Public Relations on January 1. A special committee appointed by the Board of Governors reviewed applications and selected Mr. Ulbright. He comes to the Bureau from ten years service as public relations director of Optimist International, with headquarters in St. Louis.

A graduate of the University of Missouri School of Journalism, the new Acting Supervisor has impressive experience in the organization and administration of civic clubs, conferences of local and national scope, and seminar training programs. He has planned national and regional publicity campaigns and has had opportunity to work closely with the press, radio and other news disseminating mediums.

Dr. Lorenzo L. Parks of Jacksonville, Director of the Bureau of Preventable Diseases of the Florida State Board of Health, submits the following information:

"Anthrax Cases in Broward County.

"Two human cases have been reported to the State Board of Health from this area. There have been over one hundred and thirty (130) cattle to die as a result of this disease. The State Veterinarian and his staff have quarantined this area for cattle and are immunizing them.

"Mention is made of this disease because it has been over ten years since a human case has been reported in Florida. The two cases so far reported have been of the skin type. A review of the current literature has been made by the State Board of Health and copies of this review are available upon request to the State Board of Health, Bureau of Preventable Diseases, P. O. Box 210, Jacksonville."

Drs. Jack Q. Cleveland of Coral Gables, president of the Dade County Medical Association, and Turner E. Cato of Miami, director of the Dade County Health Department, delivered welcoming addresses at the 23rd annual convention of the Florida Public Health Association in Miami.

Dr. David R. Murphey, Jr., of Tampa, president of the Florida Medical Association, reviewed the growth and accomplishments of blood banks in Florida at the ninth anniversary meeting of the Jacksonville Blood Bank on October 11.

Dr. Charles K. Donegan of St. Petersburg spoke on November 3 at the meeting of the Florida Association of Broadcasters in St. Petersburg.

Dr. John F. Lovejoy of Jacksonville was recently installed as president of the North Florida Council, Boy Scouts of America.

Dr. R. Wynn S. Owen of St. Petersburg has recently returned to his practice after a two-months absence during which he attended clinics in Indianapolis, Detroit and Cleveland.

Dr. Norman E. Williams of Daytona Beach was a guest speaker recently at a meeting of the Florida State Association of Nurse Anesthetists in Daytona Beach.

Dr. Herschel G. Cole of Tampa was guest speaker on a recent Parent-Teachers Association radio program on radio station WDAE, Tampa. His subject was, "Safeguarding Your Child Under Atomic Attack."

Dr. Donald C. Hartwell of Avon Park spoke on X-ray at a local Rotary meeting on October 3.

Dr. Solomon D. Klotz of Orlando has returned to his practice after attending a cardiovascular symposium at the New York Academy of Medicine.

Drs. Cornelius A. Bird and Ashbel C. Williams of Jacksonville were guest speakers at a recent meeting of the 8th Judicial Circuit Bar Association in Gainesville. They were presented by Dr. James M. McClamroch, president of the Alachua County Medical Society.

Dr. Mark E. Adams, formerly of Jacksonville, announces the opening of his offices in Perry.

Dr. Elmer E. Leitner of Jacksonville, president of the Florida Chapter of the American Academy of General Practice, presided at the annual fall meeting of the Chapter at Silver Springs in October. Dr. Richard C. Cumming of Ocala, president of the Marion County Medical Society, delivered the welcoming address. Florida Medical Association members on the program included Drs. David R. Murphey, Jr., Tampa, president of the Association; Walter W. Sackett, Jr., Miami; Raymond R. Killinger, Jacksonville; George F. Schmitt, Jr., Miami; John J. Cheleden, Ocala and Henry L. Harrell, Ocala. Drs. John D. Lindner and Eugene G. Peek, Jr., of Ocala and Clifford E. Vinson of Williston, formed the committee on local arrangements.

Dr. Elmer L. Henderson, immediate past president of the A. M. A., addressed the annual convention of the American Legion in Miami October 14-18. Dr. Henderson expressed appreciation to the Legion for its continued opposition to compulsory health insurance.

The fifteenth annual meeting of The New Orleans Graduate Medical Assembly will be held March 10-13, 1952 at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate and their presentations will be of interest to both specialists and general practitioners. In addition, the program will include symposia on "Resuscitation" and "Complications of Antibiotic Therapy and Their Management," daily demonstrations of medical and surgical procedures in color television, clinicopathologic conferences and medical motion pictures.

The Assembly has planned a postclinical tour by plane to Merida, Yucatan, Mexico, and other Central American localities. Arrangements have been made for medical programs and visits to hospitals in Merida and Mexico City. The group will leave New Orleans March 15, returning March 29.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

Dr. W. Terrell Simpson of Winter Haven has returned to his practice after attending postgraduate courses at the Cook County Graduate School of Medicine in Chicago.

Dr. Alvin L. Stebbins of Pensacola was recently elected president of the Gulf Coast Clinical Society at a meeting in Biloxi, Miss.

Dr. Bernard J. McCloskey of Jacksonville has returned to his practice after taking a graduate course in Allergy at the University of Pittsburg School of Medicine.

Dr. George E. Engelhard of Leesburg has been appointed by the Governor to the State Board of Medical Examiners to succeed Dr. Howard G. Holland of Leesburg who recently resigned.

Dr. Edward R. Annis of Miami recently spoke before the Miami Beach Optimist Club and at an open meeting at the Ft. Lauderdale High School auditorium under the sponsorship of the Minute Women of the U.S.A., Inc., and the Woman's Auxiliary of the Broward County Medical Society.

Contributions to the American Medical Education Foundation fund are urgently needed to help relieve the financial plight of the nation's medical schools. Your donation may be sent to Dr. Julius C. Davis, Chairman, Committee on Medical Education and Hospitals, Quincy, Florida, and it will be forwarded without delay to the Foundation. You may specify the medical school which is to receive your gift if you so desire. Contributions to this fund may be included when computing Federal income tax deductions.

The Alabama Section will be host to the Southern Assembly of International College of Surgeons, (Alabama, Tennessee, Louisiana, Mississippi, Florida, Georgia, North Carolina and South Carolina) on February 15 and 16 at the Tutwiler Hotel in Birmingham.

A full two days of surgical papers and panels is assured. All physicians and their wives are cordially invited.

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COMPONENT SOCIETY NOTES

Alachua

Dr. Henry H. Graham, secretary of the Alachua County Medical Society, read a scientific paper on new drugs at the regular monthly meeting of the Society in October.

Bay

The Bay County Medical Society held its October meeting at the Health Center Auditorium in Panama City. The scientific program was in charge of Dr. Russell T. Stewart of Panama City. Guest speaker was Dr. John H. Kay who spoke on phases of the problem of high blood pressure.

Broward

All members of the Broward County Medical Society have paid their state dues for 1951.

Dade

The editor of the Bulletin of the Dade County Medical Association is in receipt of a pleasing communication from the associate editor of the San Diego County (Calif.) Medical Bulletin. The letter reads in part:

23 September 1951

The Editor
Dade County Medical Society Bulletin
Miami, Florida
Dear Sir,

The Editors of the San Diego Medical Society Bulletin have just finished a survey of medical society bulletins the country over in order to obtain ideas how to improve their own bulletin.

It will no doubt interest you that the Dade County Medical Society Bulletin was considered the best and we hope to copy several of the features that make your bulletin so effective. Both in content and in typography, the Dade County Bulletin comes out on top.

. . . May we congratulate you on your fine work? . . .

Clifford L. Graves, M.D.
Associate Editor
San Diego County (Calif.) Medical Bulletin

Duval

"The Fenestration Operation" by Dr. G. Dekle Taylor of Jacksonville was the subject of the scientific program of the regular monthly meeting of the Duval County Medical Society on November 6 in the Sellers Auditorium.

Hillsborough

The Hillsborough County Medical Association held a joint meeting with the Pinellas County Medical Society at the Floridan Hotel in Tampa on November 6. Subject for discussion was medical public relations.

Lake

The Lake County Medical Society held its annual dinner meeting at Howey-in-the-Hills in October.

Marion

Guest speaker at the regular October meeting of the Marion County Medical Society was Dr. Jere W. Annis of Lakeland. Dr. Annis spoke on the history of heart disease and the advancements made in its control in recent years.

Monroe

The Monroe County Medical Society recently met jointly with the officers of the Medical Department of the U. S. Naval Hospital at Key West. Guest speaker was Dr. A. R. Shands, Orthopedic Surgeon, Surgeon in Chief of the Alfred I. duPont Institute, Wilmington, Del., and member of the Armed Forces Medical Policy Council for the office of the Secretary of Defense. Dr. Shands spoke on "Problems of the Low Back in Military Service."

Pinellas

At the annual meeting of the Pinellas County Medical Society in October, Dr. John P. Rowell of St. Petersburg was installed as president and presented the past president's plaque to the retiring president, Dr. Claude B. Wright. Other officers elected to serve with Dr. Rowell for the current year are president-elect Dr. Everett M. Harrison of Clearwater; first vice president, Dr. R. Wynn S. Owen and second vice president, Dr. John P. Ferrell, both of St. Petersburg. Reelected as secretary-treasurer was Dr. Whitman C. McConnell of St. Petersburg.

The Society joined with the Hillsborough County Medical Association for a discussion on medical public relations at the Floridan Hotel in Tampa on November 6.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR SALE: X-ray equipment and practice. North Florida city. Retiring for health reasons. Excellent location serving large territory. Nearest competition fifty miles. Will sacrifice. White P. O. Box 667, Lake City, Fla.

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PHYSICIAN WANTED: Florida license required. Grade A college, approved internship, eligible county society membership. For general Miami practice. Assured income. No investment. Write full details at once to 69-57, P.O. Box 1018, Jacksonville, Fla.

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OBITUARIES

James Barnett Lowry

Dr. James Barnett Lowry of Lakeland died in that city on July 22, 1951 of arteriosclerotic heart disease. He was 83 years of age. Interment took place in Lynnville, Tenn.

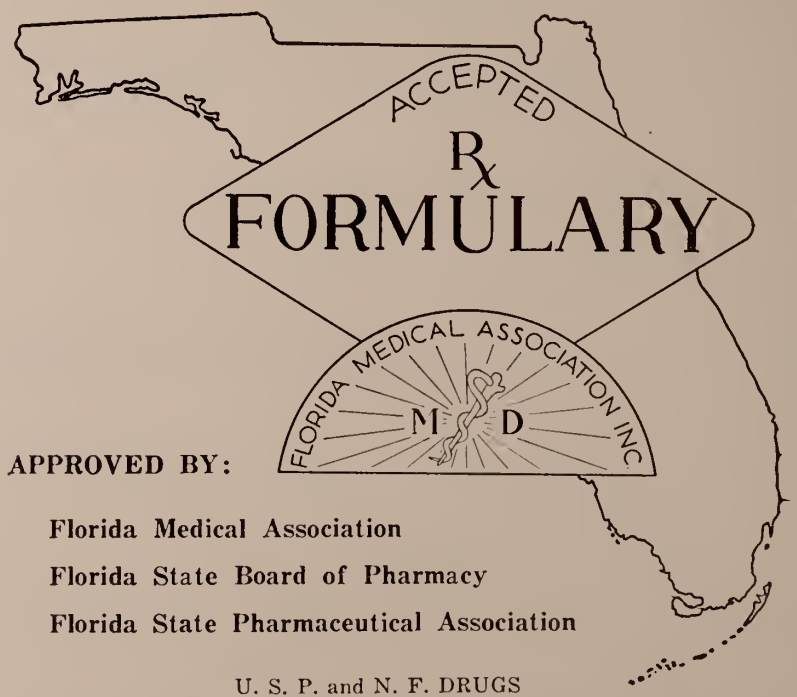
Born in Giles County, Tennessee on April 12, 1868, Dr. Lowry completed his high school education in the county schools of his native state and then attended Cumberland University in Lebanon. After receiving the Bachelor of Arts degree from that institution, he left Tennessee to study for the Master's degree at the University of Michigan, but returned to pursue his medical education at Vanderbilt University School of Medicine, where he was awarded the degree of Doctor of Medicine in 1894.

After engaging in the general practice of medicine in Tennessee for some years, Dr. Lowry went to South America as a physician for a group of workers of the Guayaquil and Quito Railroad Company, which was constructing a road across the Andes Mountains. Upon returning to the United States, he was associated with the Tennessee Sulphur, Copper and Iron Company at Copperhill, Tenn. He came to Florida as company physician for the Phosphate Mining Company at Nichols and the American Cyanamid Company at Brewster, where he remained until a few years before his death. After retirement because of age and ill health, he made his home in Lakeland.

This much respected and loved member of the medical profession was a member of the Polk County Medical Society. For a quarter of a century he held membership in the Florida Medical Association, and he was also a member of the American Medical Association.

Dr. Lowry's widow survives him.

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From where I sit
by Joe Marsh

Easy Makes His "Cat" Tread Lightly

Driving home on Three Ponds Road yesterday, I was flagged down by Easy Roberts' boy Skeeter. "Take it slow," he advised. "Dad's crossing with our tractor, just beyond the bend."

Around the curve I saw why Skeeter stopped me. Easy had laid two rows of old truck tires across the road, and was driving his new "Cat" tractor over them!

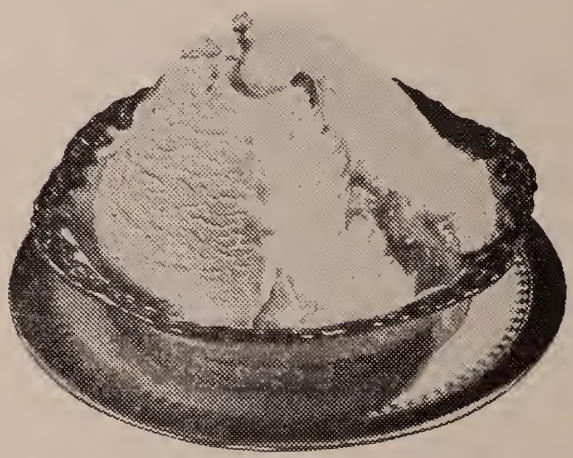
"A little more trouble this way," Easy explains, "but it keeps those tracks from tearing up the asphalt when I cross over to our other fields. After all, the roads belong to all of us—and I guess I'd get mad if someone else chewed them up."

From where I sit, Easy is my kind of citizen. He doesn't just give democracy lip service—unlike certain other people who are always prescribing what "road" we should take. Whether it's practicing a profession, the choice of your favorite beverage, or the right to use the public highways, I figure it's up to all of us to protect every individual's "right of way."

Joe Marsh

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Certain Policies and Procedures

The policies outlined last year for the Woman's Auxiliary by Dr. Herbert E. White, then president, and reaffirmed this year by the officers of the Florida Medical Association under Dr. David R. Murphey, Jr., president, indicate the desired course of action expected of the doctors' wives and reveal the growing importance of the Auxiliary to the Florida Medical Association in its public relations program.

1. Organization: There should be a Woman's Auxiliary to every county medical society.

2. Public Relations: It is in order for local Woman's Auxiliaries to obtain resolutions against compulsory health insurance (not socialized medicine) from (1) Parent-Teachers Associations, (2) The American Association of University Women, (3) The Florida Nurses Association, etc. This should be done in cooperation with, or under the supervision of, the Association's regular Committee on Public Relations. If additional tasks in the public relations field are desired by the Woman's Auxiliary, it is suggested that this information also be obtained from the Association's Committee on Public Relations.

3. Liaison: The Chairman of the Association's Committee on Legislation and Public Policy should notify the Chairman of the Auxiliaries' Legislation Committees concerning any bill in the Legislature on which help is needed. Also, the county auxiliaries should cooperate with the county medical societies' legislative committees. This work on a county level is most effective. This liaison should not necessarily be limited to legislation and public policy. There are many other standing committees that would be greatly helped through aid from the county and state auxiliaries. The committee personnel on all regular committees is shown each month in The Journal.

4. Policy on Fund Raising: The Florida Medical Association does not have any fund raising drives. It is financed by dues from its members, advertising in The Journal, Directory, etc. The Association does not assist the host of worthy organizations in their efforts to raise money. As individuals the members make their own personal choices. The Woman's Auxiliary to the Association should follow the same course.

5. Raising Money for Outside Organizations: Since the State Association and its Woman's Auxiliary were not created nor organized for fund raising purposes it would follow that it is against the policy of the organization to put on drives for outside organizations under its own name. In place of going out under its own name, splendid service by individual workers from the Woman's Auxiliary can be advantageous to these groups.

6. Educational Activities: Education shall take precedence over more material things as an aim of the Woman's Auxiliary. Educational activities should be considered the major charge.

7. Auxiliary Membership: All wives of members in good standing in their respective societies should be invited to join the Auxiliary. The wives of all such medical members should be eligible for membership in the Auxiliary provided they are ethical and of character. In some local county medical societies that have not yet organized a Woman's Auxiliary, those wives have been capable members-at-large.

At no time has the discussion of this organization been of such paramount importance. Because we have grown with rapidity throughout the state, it is imperative that we do not underestimate the far reaching effects of our influence upon the profession, within the auxiliary, as well as in the community. That is why education takes precedence over any other single auxiliary activity. For unless we are aware of the issues which affect the medical profession, understand the organization which is formed to extend the aims of this profession and share that knowledge with the public, we fail to serve our doctors and our organization as well as the community.

When the doctor was singled out for inspection and re-evaluation by a new trend in public opinion, he was unprepared because he was looking the other way. He came to the realization that he could no longer take umbrage in professional obscurity, isolating himself to the care of sick bodies when unhealthy thinking manifested itself; and he realized that we owe it to our country, our children and to ourselves to be active, informed and contributing citizens. The doctor's wife can do no less.

If you examine the issues which affect the doctors you will see they affect the welfare of the country even more, so we needn't feel there is selfish professional interest in studying these trends.

If you examine the nature of the Auxiliary you will find that each job is a contribution to the community if properly fulfilled so we needn't feel we are taking time from civic organizations to belong.

We have the material. We have the workers. We have a job to do. The work of this year will be to correlate these factors into a driving force for good.

The work-shops and committee chairmen can show you *how — why — when,* but each of us must find within herself sufficient faith in and loyalty to our ideals, our doctors and our country, to make the necessary effort self-education demands.

Mrs. C. Robert DeArmas, President

Cook County Graduate School of Medicine
ANNOUNCES CONTINUOUS COURSES

SURGERY — Intensive Course in Surgical Technic, Two Weeks, starting January 21, February 4, February 18. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 3, June 2. Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 17, June 16. Surgery of Colon & Rectum, One Week, starting March 3, April 7. Gallbladder Surgery, Ten Hours, starting April 21. Basic Principles in General Surgery, Two Weeks, starting December 10, March 31. Breast & Thyroid Surgery, One Week, starting June 23. Esophageal Surgery, One Week, starting June 23. Thoracic Surgery, One Week, starting June 2.

GYNECOLOGY — Intensive Course, Two Weeks, starting February 18, March 17. Vaginal Approach to Pelvic Surgery, One Week, starting March 3, March 31.

OBSTETRICS — Intensive Course, Two Weeks, starting March 3, March 31.

MEDICINE — Intensive General Course, Two Weeks, starting May 5. Electrocardiography & Heart Disease, Two Weeks, starting March 17. Gastroenterology, Two Weeks, starting May 19. Hematology, One Week, starting June 16.

UROLOGY — Intensive Course, Two Weeks, starting April 28. Ten Day Practical Course in Cystoscopy starting January 7, January 21, and every two weeks.

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John H. Lamb, M.D., Oklahoma City, Okla.
Dermatology

J. Arnold Bargen, M.D., Rochester, Minn.
Gastroenterology

Ralph A. Reis, M.D., Chicago, Ill.
Gynecology

Charles A. Doan, M. D., Columbus, Ohio
Medicine

John P. Merrill, M. D., Boston, Mass.
Medicine

William Parson, M.D., Charlottesville, Va.
Medicine

Jacob E. Finesinger, M.D., Baltimore, Md.
Neuropsychiatry

Leroy A. Calkins, M.D., Kansas City, Kan.
Obstetrics

John H. Dunnington, M.D., New York, N. Y.
Ophthalmology

Edward L. Compere, M.D., Chicago, Ill.
Orthopedic Surgery

Hayes Martin, M.D., New York, N. Y.
Otolaryngology

Oscar B. Hunter, Sr., M.D., Washington, D. C.
Pathology

Margaret M. Nicholson, M.D., Washington, D. C.
Pediatrics

Paul C. Swenson, M.D., Philadelphia, Pa.
Radiology

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**Gosselin, George A., M.D. Neurology and Physiology in Functional States Connecticut State Medical Journal 15: 109-113, (February) 1951*

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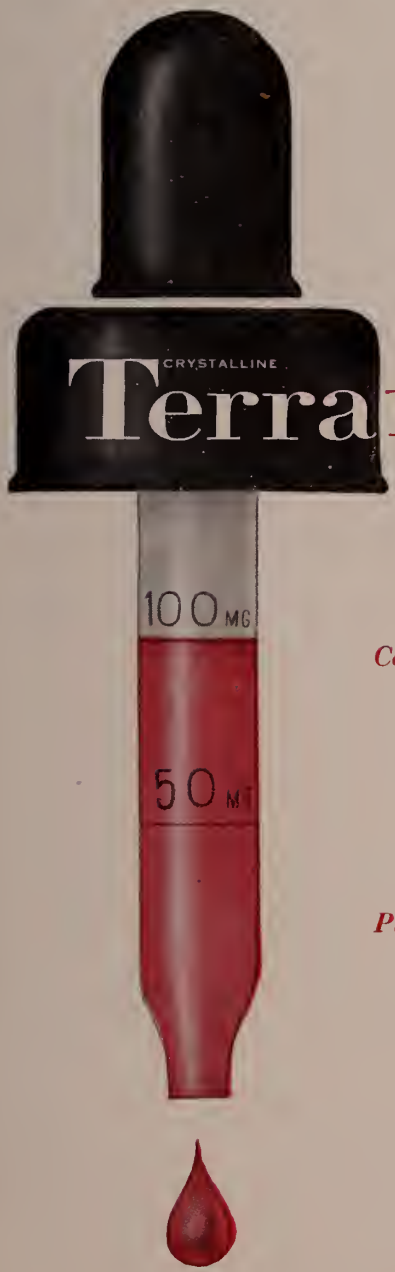
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ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
da Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '52
da Medical Districts	William C. Roberts, Panama City	Council Chairman	
Northwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Panama City, 1952
Northeast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Daytona Beach, 1952
Southwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	St. Petersburg, 1952
Southeast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Ft. Pierce, 1952
da Specialty Societies			
emy of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	Hollywood, Apr. 27, '52
gy Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	" "
thesiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
ter, Am. Coll. Chest Phys	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
n. and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
th Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
t Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	" "
strial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	" "
ology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
nd Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
hal & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	" "
opedic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	" "
ological Society	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Laudardale	" "
atric Association, State	Edgar E. Hitchcock, Orlando	Charlotte C. Maguire, Orlando	
cologic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	Hollywood, Apr. 27, '52
ological Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
gical Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
da—			
sic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	
od Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
ue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Orlando, Dec. 2, '51
ue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 27, '52
ntal Society, State	John I. Todd, D.D.S., Jacksonville	Tom Price, D.D.S., Miami	Jacksonville, Apr. 20-23, '52
spital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	Orlando, Dec. 3-4, '51
dical Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	
dical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
rses Association, State	Miss Undine Sams, Miami	Miss Helen Shearston, Miami	St. Petersburg, Nov. 14-16, '52
armaceutical Association, State	Mr. Euless Watford, Chipley	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-21, '52
blic Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct., '52
berculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Pt. St. Joe	
oman's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	Hollywood, Apr. 27-29, '52
rican Medical Association	John W. Cline, San Francisco	Geo. F. Lull, Chicago	
M.A. Clinical Session	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Los Angeles, Dec. 4-7, '51
hern Medical Association	Curtice Rosser, Dallas, Texas	Mr. C. P. Loranz, Birmingham	
ama Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19, '52
gia, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 11-14, '52
Hospital Conference	Edwin B. Peel, Atlanta	Mr. R. G. Ramsey, Jr., Memphis	Atlanta, Apr. 16-18, '52
heastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath, B, MacInnis, Columbia, S.C.	Augusta, Ga., Mar. 21-22, '52
heastern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	Boca Raton, Apr. 2-5, '52
heastern Surgical Congress	Joseph S. Stewart, Miami	B. T. Beasley, Atlanta	Atlanta, Mar. 10-13, '52
Coast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct., '52



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	Escambia *Santa Rosa*	Lee Sharp, M.D. Box 151 Pensacola	Arthur J. Butt, M.D. 1101 N. Palafox St. Pensacola	2nd Tuesday 8:00 P.M.	74	69	
	Franklin-Gulf	William P. Blackmon, M.D. Box 157 Apalachicola	Albert L. Ward, M.D. Port St. Joe	Last Wednesday	7	100%	
	Jackson-Calhoun	Jasper B. Dowling, M.D. Route 1 Altha	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	15	
	Walton-Okaloosa	Arthur G. Williams, Jr., M.D. Valparaiso	Ralph B. Spires, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	100%	
	Washington-Holmes	N. J. Dawkins, M.D. Vernon	B. W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker-Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	17	16	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Ernest W. Ekelmeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	57	56	
	Suwannee	John N. Sims, Sr., M.D. Suwannee St. Live Oak	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	100%	
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		3	100%	
	Taylor *Dixie-Lafayette*	Ralph J. Greene, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	3	100%	228
B	Alachua *Bradford, Gilchrist, Union*	James M. McClamroch, M.D. 903 S.W. 4th Ave. Gainesville	Henry H. Graham, M.D. 819 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	46	100%	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Duval *Clay*	Charles F. Henley, M.D. 441 W. Duval St. Jacksonville	C. Burling Roesch, M.D. 1060 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	251	246	
	Marion *Levy*	Richard C. Cumming, M.D. Commercial Bank Bldg. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	27	100%	
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	Lake *Sumter*	H. Durham Young, Jr., M.D. 411 Lakeshore Dr. Leesburg	Lawton F. Douglass, M.D. Umatilla	1st Wednesday 7:30 P.M.	27	26	
	Orange *Osceola*	Fred Mathers, M.D. 314 American Bldg. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	151	100%	
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C	Hillsborough	R. Renfro Duke, M.D. 708 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	165	164	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Manatee	Roderic O. Jones, M.D. 430 10th St., W. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	22	20	
	Pasco-Hernando-Citrus	Gail M. Osterhout, M.D. Box 296 Inverness	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	13	100%	
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	184	183	
	Sarasota	Sherrel D. Patton, M.D. 323 Commercial Ct. Sarasota	Millard B. White, M.D. 203 Van Skike Bldg. Sarasota	2nd Tuesday 8:30 P.M.	42	41	
	DeSoto-Hardee-Highlands-Glades	Hubert W. Coleman, M.D. Box 98 Avon Park	Stanley K. Wallace, M.D. Sebring	2nd Tuesday 8:00 P.M.	26	24	C-6-52 Leldon W. Martin, M.D. Sebring
	Lee-Charlotte-Collier-Hendry	William H. Grace, M.D. 1925 McGregor Blvd. Ft. Myers	Angus D. Grace, M.D. 308 Richards Bldg. Ft. Myers	3rd Monday 7:30 P.M.	23	100%	
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D	Indian River	Erasmus B. Hardee, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	100%	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	Palm Beach	R. M. Overstreet, Jr., M.D. 820 Comeau Bldg. West Palm Beach	Lorenzo James, M.D. 1300 N. Dixie Ave. West Palm Beach	3rd Monday 8:00 P.M.	109	105	
	St. Lucie-Okeechobee-Martin	Julian D. Parker, M.D. Box 942 Stuart	Adrian M. Sample, M.D. Box 897 Ft. Pierce	3rd Thursday 8:00 P.M.	16	14	
	Broward	M. Austin Lovejoy, M.D. 409 Blount Bldg. Ft. Lauderdale	Thomas L. Roberts, Jr., M.D. 408 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	80	100%	D-8-53 Donald W. Smith, M.D. Miami
	Dade	Jack Q. Cleveland, M.D. 167 Alcazar Ave. Coral Gables	R. B. Chrisman, Jr., M.D. 743 duPont Bldg. Miami	1st Tuesday 8:30 P.M.	587	563	
	Monroe	Ralph Herz, M.D. 420 Simonton St. Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	10	100%	809

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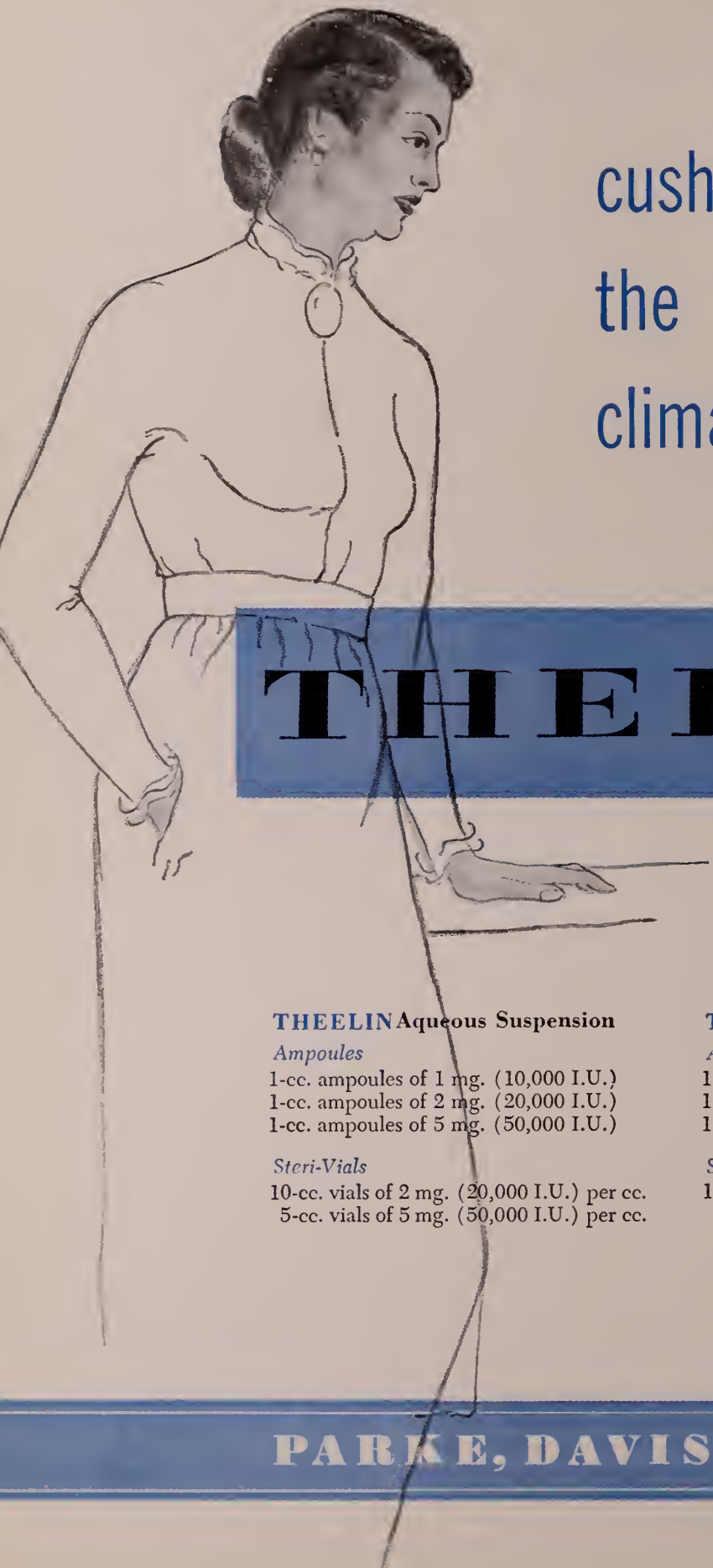
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Joseph W. Taylor, Jr.

Stress and General Adaptation Syndrome
Joseph G. Seltzer

January Anniversaries
An Editorial

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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1. Moss, Henry N., and D'Alessandro, Domenic R.: The intensity and duration of the effect of Depo-Heparin on venous coagulation time in man. Am. Practitioner & Dig. of Treatment 2:309 (April) 1951

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The formerly held tenet that protein intake should be restricted for all patients with impaired renal function, in order to afford the kidney physiologic "rest," is no longer valid.[1] Except for infection and some neoplastic and traumatic disorders, the treatment of renal disease is nonspecific and essentially symptomatic. The clinical problem centers largely on diet regulation, in the hope of stimulating the kidneys to improve impaired function, without unduly risking harm.

Even in the presence of azotemia, a protein intake of 60 to 80 Gm. per day has not been found harmful to the renal patient. Low protein intake, on the other hand, together with urinary loss of protein may encourage the development of asthenia, anemia, hypoproteinemia, and edema.[2] Also pertinent to the dietary management in renal disease is the experimental finding that high protein diets in normal dogs promote higher urea clearance and greater renal blood flow than do low protein diets.[3,4]

Except in anuria, a protein intake adequate to maintain nitrogen balance has been suggested.[1] Although as little as 30 to 40 Gm. of protein per day may suffice for this purpose in the fever-free patient at bed rest, few occasions arise when 1 Gm. of protein per day per kilogram of body weight may not be given safely. In the presence of significant proteinuria, unless specifically contraindicated, the dietary protein may be increased beyond that amount in order to counterbalance the urinary protein loss.

Contrary to the still prevalent ancient belief among the laity, red meats are just as harmless to the renal patient as white meats; nor is there evidence that plant proteins are more beneficial in nephritis than animal proteins. As with the normal person, the dietary protein of the patient should be of high biologic value.

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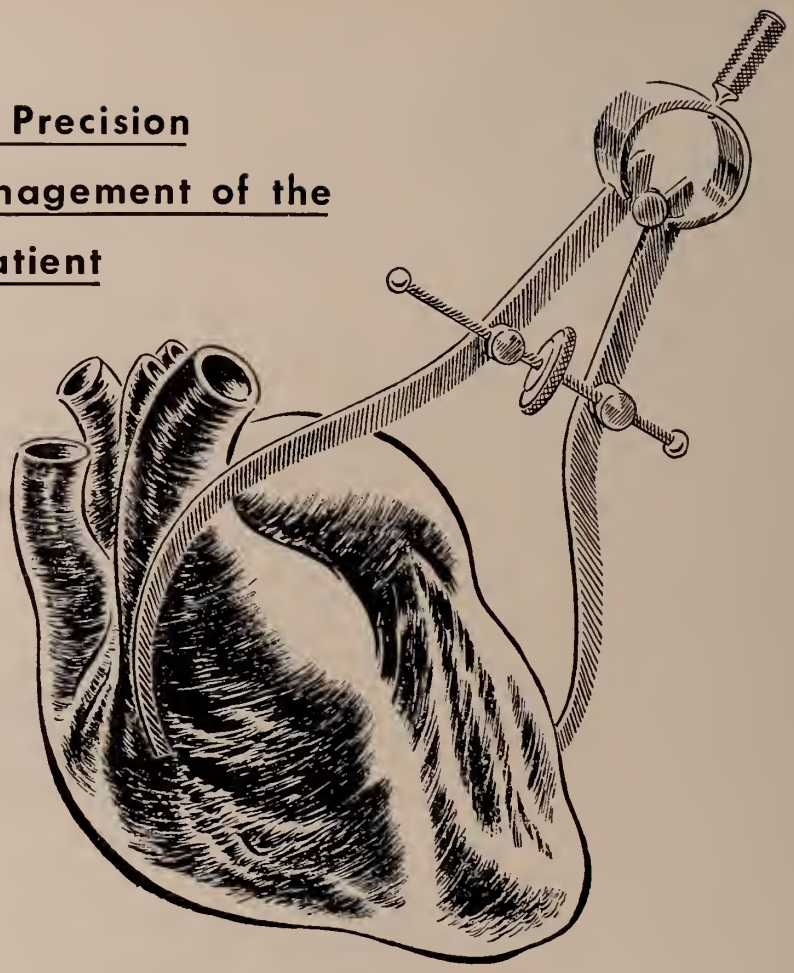
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Potterfield, T. G., and Starkweather, G. A.:
J. Philadelphia General Hosp. 2:6 (Jan.) 1951.

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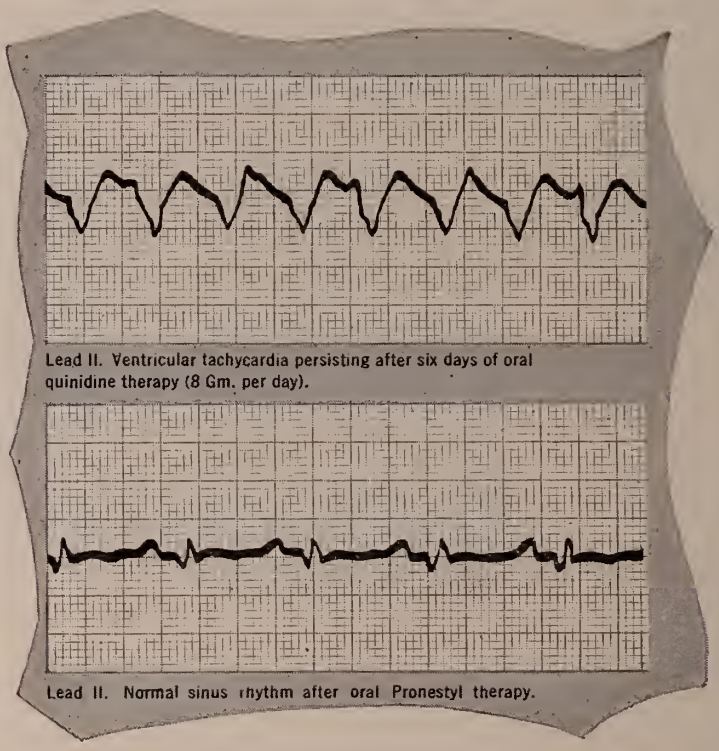
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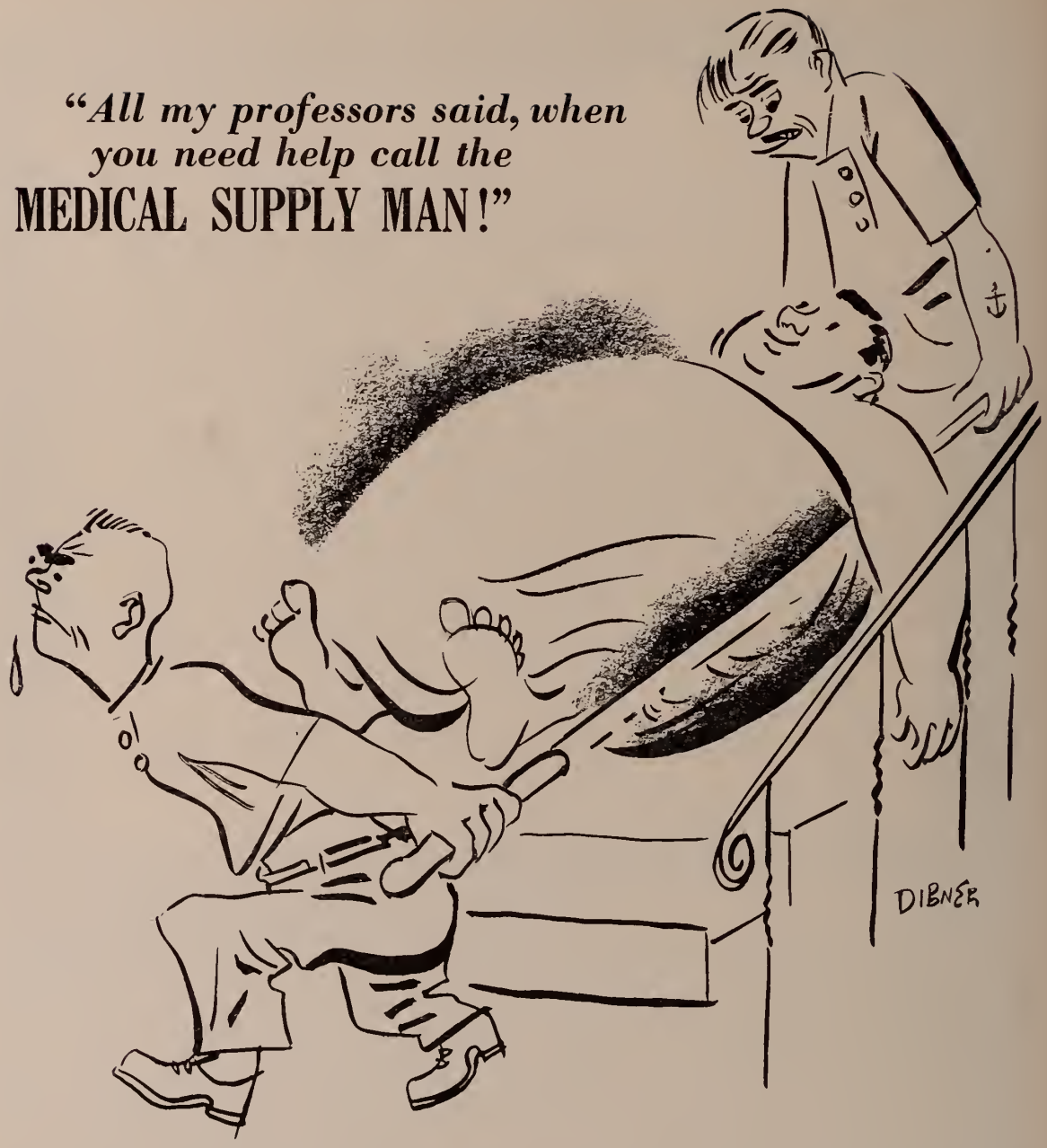
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Norcross, B. M., *N. Y. State J. Med.* 51: 2356, Oct. 15, 1951.

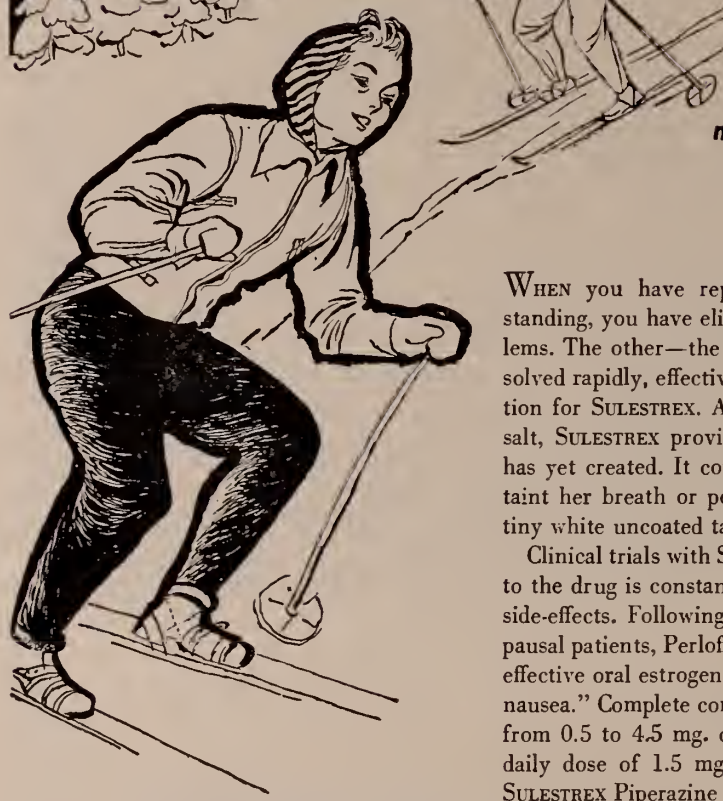
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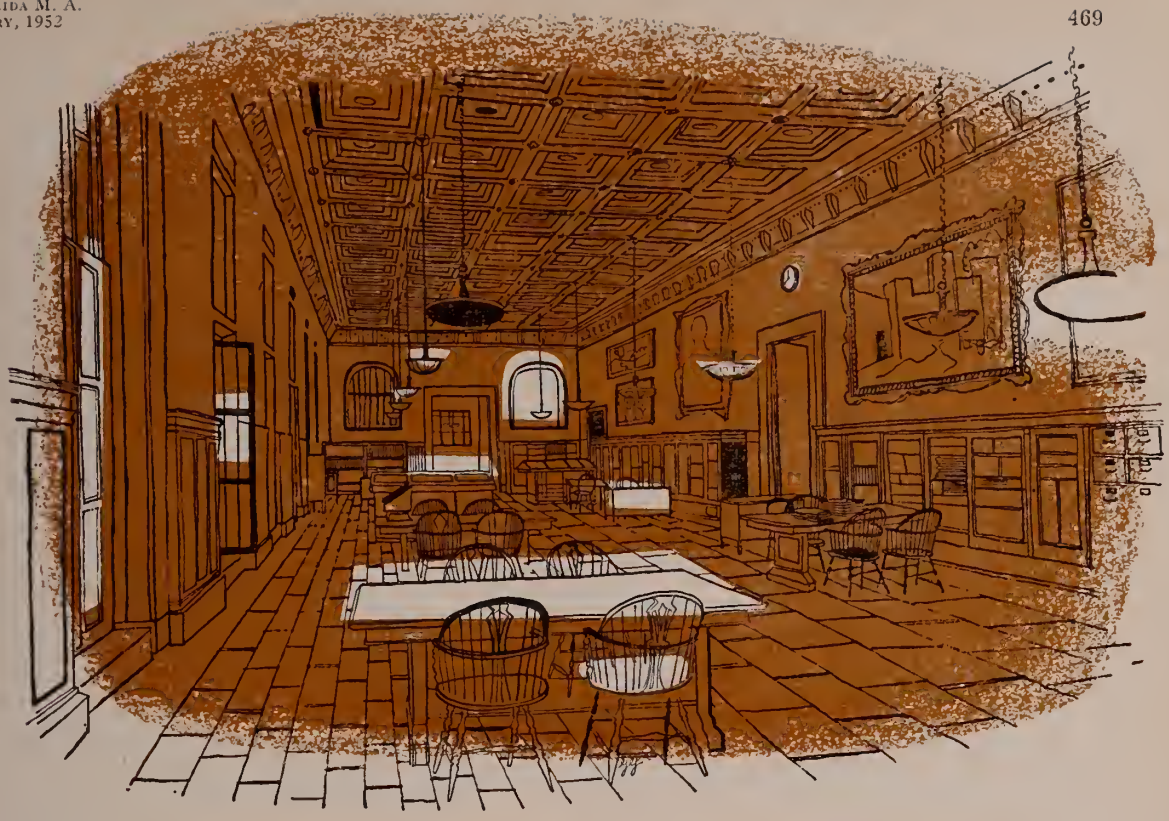
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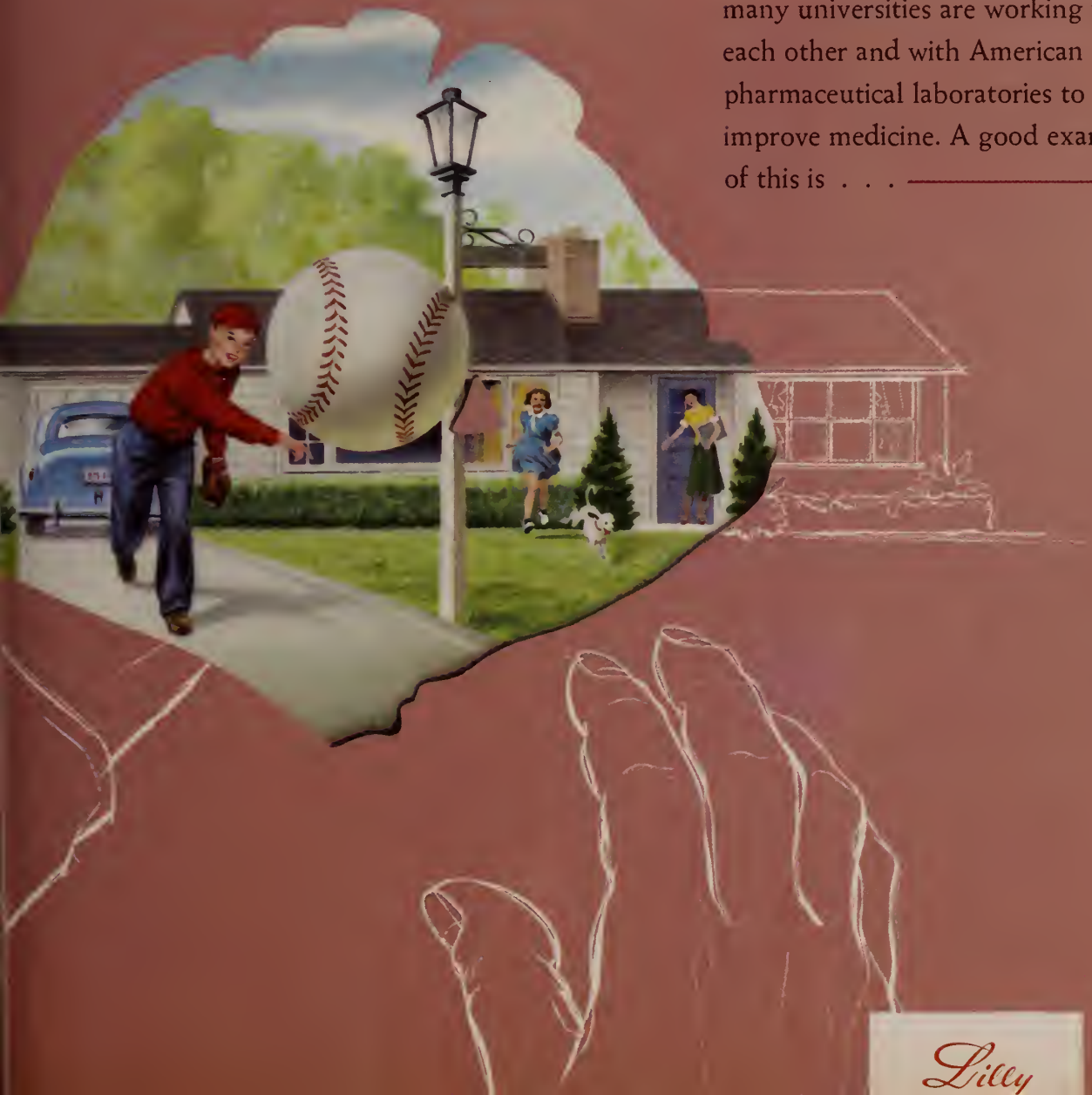
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXVIII Jacksonville, Florida, January, 1952 No. 7

The Role of Cancer Cytology in Medical Practice

J. Ernest Ayre, M.D.
MIAMI

I appreciate the opportunity of presenting a new prospect for cytodiagnosis in the hands of the family doctor to further the control of cancer.

It is difficult to find early cancer and easy to cure it. It is easy to find late cancer but difficult to cure it. This situation has been a strong retarding force in the inability of the medical profession to diminish the ravages of malignant disease.

Cytology is bringing about a changing concept of cancer control. The cell method offers earlier diagnosis of many types of cancer than has ever been possible before. Cytology has consistently been kept subservient to histologic methods. The cytologic method is not offered as an alternative to the biopsy method but rather to complement it. If either method alone will give 90 per cent accuracy, the combination of the two methods will give 99 per cent accuracy. Many pathologists are interested in and desirous of furthering cancer diagnosis. Unfortunately, there are too few pathologists. They are already overworked and they are naturally appalled at the time required for screening and cytodiagnosis. The answer to this problem lies in the training of large numbers of cytotechnologists (nonmedical screeners) to work in collaboration with pathologists or cytologists in regional cytology centers.

Recently, a national organization of cytology has been formed under the leadership of Arthur Purdy Stout in New York. While a number of cytology centers are already developing in scientific medicine, others are needed. In New York, under Papanicolaou at Cornell, a large cytology center is being developed in collaboration with Memorial Hospital and the City of New York. In Duke University, under the sponsorship of Dr. Carter and Dr. Cuyler, the cytologist, a particularly active program is under way. In Philadelphia, under Dr. Sheffey and Dr. Rakoff, an active program for more widespread screening by the cytologic method is under way. It is our hope to set up a cytology center in Florida at the Dade County Cancer Institute which will render cytodiagnosis equal to that of other leading cytology centers already in existence. The national cytology organization has unanimously endorsed regional cytology centers which will make available to the family physician cytologic service as a part of the general health check-up of patients in the doctor's office. No matter how remote the doctor may be from the cytology center, the specimen for the test may readily be mailed in to the center for efficient screening and diagnosis, and many early and curable cancers will be found as a result of more frequent testing.

A recent article in the Reader's Digest stressed the importance of the role of the family doctor. As far as it went it was excellent, although it did not say exactly how the doctor was going to find early cancer, which is not too easy a problem to solve.

Cancer of the stomach or bowel cannot be diagnosed early enough for frequent cures today. In the doctor's office skin cancer may be searched for and frequently found curable. Similarly, cancer of the breast may be frequently found by physical examination, but with the utilization of the cytotest for cancer, such common cancers as those of the uterus, the lung, the prostate, the tongue, the bladder and the kidney may be diagnosed at an early stage and better hope for cure held out. The

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 23, 1951.

use of cytology puts "teeth" into the program of making the family doctor's office a cancer detection center.

It is good medical practice to advise all persons over 40 to have a routine health examination once a year. It should be advised that all women over 30 or 35 have a routine cervical cytologic test as part of this health examination. In men, whenever there is an obscure pulmonary lesion or doubtful roentgen evidence, cytologic examination of the sputum should be utilized. Similarly, if there is suspicion of cancer of the stomach or prostate, cytologic tests may be used as an adjunct to the physical examination by the physician in his office.

Cytologic Examination of the Sputum

In the lung cytologic examination offers the earliest form of diagnosis of cancer. Macdonald of the Mayo Clinic stated that there are many inmates of sanatoriums actually suffering from pulmonary cancer and advocated more or less routine examination of the sputum for cells which may lead to earlier diagnosis in these cases. Ochsner advocated that persons who have had virus pneumonia should have the sputum examined in subsequent years. Most opinions suggest that smoking increases cancer of the lung. In any case, it is surprising to note the increased frequency. In men, pulmonary cancer is equal to and in many series more frequent than gastric cancer today.

Regarding collection of sputum, it is simply necessary to have the patient spit into a bottle of alcohol, and this sample may be mailed to the center. Three separate specimens on successive days are advised in order to permit adequate search of the specimens.

Uterine Cancer

In two departments the cytologic method is superior to all other methods in the detection of early cancer. One of these is the lung, which has been discussed. Second is the uterus and cervix. At the present time some 26,000 women die annually from uterine cancer in America. The majority of the lesions arise from the cervix, the neck of the womb, and in this type of cancer, the chances are better than in any other for detection of the cancer while in the preclinical and unsuspected stage. Twenty thousand could be saved. You would be surprised if I told you that if you have a gynecologic practice and were to take a routine cell scraping from the cervix on the next 100 women who pass through your office, you would find 1 of these to be harboring an incipient cancer which today can be cured in your hands. Yet this is precisely the situation which I have found in screening programs on groups of apparently well patients or at least patients free of clinical evidence of malignant disease.

In the past, abnormal bleeding or a suspicious ulceration was the first indication for biospy of the cervix. It is for this reason that early curable cancer was not commonly found. Today the situation is radically different. The routine testing of cervical cytologic specimens in women over 30 or 35 as part of a health examination should offer a means of almost complete control of this type of cancer. As such screening programs become more complete, clinical (late) cancer of the cervix should disappear in the population and only carcinoma in situ would be found. This happy situation could be brought about in a period of four or five years in a city like Miami if routine testing of the cervical cells by the physician became the rule. In other words, practically all such cancers would be found when curable.

Here is a case which illustrates how efficiently a cervical cell test mailed from the doctor's office might have saved the patient's life. The physician states: "In April 1948 I took a cervical smear on a 40 year old patient and sent it into your laboratory, which reported positive cells. I did multiple biopsies from the cervix and sent them to the government tissue laboratory, which sent back a negative report. The patient returned to my office in 1950. I took another test of the lesion, nodular to the touch and showing ulceration around the cervix. The repeat test was again positive, but the cancer by this time was evident clinically, and the patient has been referred to the Ottawa Cancer Clinic for radiotherapy. I asked how long malignant cells could be present before being detected clinically. The lesion here was not found in the tissue search two years before, although the cytotest was positive. Two years were lost and perhaps the patient's life." This case illustrates that one must not be satisfied with a single negative biopsy when positive cytologic reaction is demonstrable. Complete and adequate surgical biopsies must be sought in order to safeguard the patient's welfare.

Research

Cytologic research is of great importance in the human cervix. The origin of epidermoid cancer is known to be at the squamocolumnar junction. The cell scraping, the surface cell biopsy, from this area using the spatula offers a technic of detecting carcinoma in situ with great regularity. In addition, however, the type of anaplastic cell, which has been called the "precancer cell-complex" offers a problem for research. Cell behavior studies have been made to determine whether this type of cell invariably is followed by cancer or whether regression may occur.

Similarly, research offers an opportunity to experiment directly upon this precancer cell in an effort to determine whether chemotherapeutic agents or antibiotics may be found which will cause the cell to heal or revert to normal. If this objective can be achieved, then it will point the direction for a similar attack upon the full-blown cancer cell. We have already achieved initial success in this field of research. Aureomycin has shown an important effect upon the "precancer cell-complex." It is our plan to develop this important lead on an expanded research basis in our new Cancer Cytology Center at the Dade County Cancer Institute and the Medical Research Foundation of Dade County. We do not understand what is happening or why, but the fact that these anaplastic precancer cells suddenly disappear from the surface cell biopsy after previously being present for one to two years suggests an important effect. We are developing a team of cytochemists and biochemists to correlate the clinical and cytologic manifestations in this type of disease.

Confirmation of the specific character of cells of the "precancer cell-complex" type reported by our group at McGill University in 1947 has recently come from a number of European centers, one in particular from Amsterdam, Holland.

In the field of training and education, it is planned in the cytology center in Florida to train doctors who wish to study to become cytologists and technicians who desire to master cytologic screening. Since this is a focal point for the Caribbean and South American area, it is anticipated that many of those who have shown keen interest in cytology will be attracted to this new training center. There is a great scarcity of well trained cytologists and cytotechnologists, and only when this deficiency is corrected will widespread cytologic screening be possible in all parts of the world.

The advantage of the regional cytology center program of cancer detection is that the doctor keeps his own patient, takes the specimen for the test in his office and mails it to the center. Cancer presents the greatest challenge to the physician to find and protect his patient from this most deadly of diseases. It is also true that the patient prefers to remain under the care of the physician of his choice.

An excellent suggestion was made by a prominent surgeon of Miami. He proposed testing the wives of doctors thoroughly for cancer every year and giving them a careful physical examination. Over a period of years this experiment would constitute important research and set a fine example for other women.

In cytology centers screening for cancer will soon parallel screening for tuberculosis in the various antituberculosis programs which have proved most successful in curbing the ravages of this disease.

The screening in industry of well patients provides a highly promising prospect. In an early group which we tested, in some 500 consecutive cases 5 curable cancers were found. In the nurse in charge of one industrial group there was found an unsuspected early invasive cancer of the cervix, still curable.

Modus Operandi

The Cytology Center of the Dade County Cancer Institute is now ready to offer diagnostic service to physicians of the area. Its program is supported by pathologists and endorsed by the Dade County Medical Association. The many highly trained physicians and specialists already in the Miami area are focusing attention upon this coming medical center where sick persons can secure both a healthy climate and expert medical care. It is no longer necessary for seriously ill patients to travel to distant clinics in New York or elsewhere to obtain the services of specialists.

The training and research program in this new field adds another special field of endeavor to medical training, as Miami, the focal point of the Pan-American area, assumes increasing stature as a center of medical training and education. It is to be hoped that it will assume a leading role in this new field, just as it has already taken the lead in many other specialties.

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VOLUME XXXVIII
NUMBER 7

Esophageal Hiatal Hernia Associated With Myocardial Infarction

WALKER STAMPS, M.D.
JACKSONVILLE

Esophageal hiatal hernia presents no characteristic clinical picture and readily simulates a variety of gastrointestinal, respiratory and cardiac diseases, one of which is myocardial infarction. This anomaly has been reported with increasing frequency in the literature in recent years, but its role of mimic can hardly be stressed unduly. Described by Harrington[1a] as the "masquerader" of the upper part of the abdomen, it may be particularly deceptive when it occurs with cardiac disease. Since both are associated with advancing years, their occurrence together is doubtless not as unusual as it might seem. The case reported here illustrates the confusing similarity of the manifestations of esophageal hiatal hernia and myocardial infarction when these disorders occur concomitantly.

Incidence

Diaphragmatic hernia was diagnosed in 650 patients at the Mayo Clinic from 1926 through 1939.[1b] It doubtless occurs more frequently than reports would indicate, for some patients are asymptomatic, others with symptoms are not subjected to roentgen examination, and in still others the hernia may not be demonstrable by this method at the particular time.

Herniation of the stomach through the esophageal opening in the diaphragm is a disease of middle and later life, rarely present before the fourth decade, but occurring typically after 50 years of age. In the light of senile degenerative changes which result in loss of elasticity and insufficiency of the hiatal tissues, the average age of from 54 to 57 years is understandable.[2a] Hurst[3] cited Schatzke as inducing hiatal herniation in 70 per cent of patients more than 60 years old simply by using greater than normal intra-abdominal pressure during gastrointestinal fluoroscopy. In the series of 110 cases of esophageal hiatal hernia recently reported by Clerf, Shallow, Putney and Fry,[4] the ages ranged from 29 to 78 years; 78 patients were between the ages of 50 and 70, 40 patients were between 60 and 70, and only 7 patients were less than 40 years of age.

In this series there was no significant sex predilection. Of the 110 patients, 59 were women and 51 were men.

Etiology

Diaphragmatic hernias may be either of traumatic or nontraumatic origin. The nontraumatic type may also be classified as congenital, being present at birth, or acquired, developing through a congenitally weakened or deformed diaphragm.[1,5]

Senile degenerative changes in the diaphragmatic musculature may cause weakening and widening of the esophageal hiatus. The abnormal stress incident to frequent or prolonged coughing may stretch and tear the tissues of this orifice, as may retching and vomiting. Also, the increased abdominal pressure from obesity may induce herniation, notably when there is a muscular abdominal wall. Less frequently, ascites and large tumors may be etiologic factors.[2a] Esophageal hiatal hernia was present in 18 per cent of the 195 pregnant women in a series of cases reported by Rigler and Eneboe,[6] and in 3 of 10 of these patients examined after delivery, there was still evidence of herniation.

The association of hiatal hernia with other pathologic conditions of the upper part of the abdomen, such as cholelithiasis, is noteworthy. In a study of duodenal diverticula, Weintraub and Tuggle[7] noted its presence in 9 per cent of the cases in contrast to 2.4 per cent of a large number of control cases. In Gilbert's series, there was concomitant abnormality of the upper part of the abdomen in 42 per cent, and diverticulum of the esophagus was present in 10 per cent.[2a] The etiologic relationship, however, if any, remains problematic

Suggesting a viscero-visceral reflex and confirming earlier animal experimentation with faradic stimulation of the vagus, Gilbert, Dey and Rall[2b]

demonstrated that the traction of the shortened esophagus will pull the stomach up above the diaphragm. In addition, they induced a reflex shortening of the esophagus which duplicated the results of electrical stimulation of the vagus merely by handling the liver, by dilating the gallbladder or the cystic duct, or by stretching the walls of the stomach.

Emotional factors, nervousness and fatigue have been mentioned as causative agents.[3] Citing illustrative cases, Gilbert[2a] concluded that nervous influences alone, entirely aside from viscero-visceral reflexes, can be the determining factor in a type of hernia caused by traction from above through an esophagus shortened by these influences. Reduction of the hernia has been many times demonstrated when the emotional stress is alleviated. The therapeutic relief with atropine offers further evidence for this mechanism.

Symptoms

Although symptoms may begin in childhood when the hernia is congenital in origin, they most frequently become apparent in the sixth decade since the hernia has a tendency to become larger as the patient grows older. In the series reported by Clerf and his associates,[4] dysphagia and pain were the outstanding primary symptoms, followed in the order of frequency by indigestion, regurgitation, lodgment of food, hemorrhage, weakness, loss of weight and hoarseness. Many patients had several complaints, including vomiting and coughing, with dysphagia and pain taking precedence; some were symptomless. Other authors mentioned, in addition, severe dyspnea, anemia, and palpitation.

Dysphagia is encountered with both liquids and solids, but solid foods commonly cause the most distress, necessitating the ingestion of small amounts of food at frequent intervals. The pain is variable in character, location and extent. If in the chest, it may be precordial or may radiate upward in the shoulder even to the throat or jaw, or downward into the abdomen. Epigastric pain may follow ingestion of food, especially a heavy meal, and may be relieved by belching or vomiting. The duration of the pain may vary from a few minutes to hours. The attacks, mild at first, increase in frequency and severity as the stomach becomes fixed by adhesions in the thorax.[4]

The patient usually discovers that lying down aggravates the symptoms, while sitting or standing affords a measure of comfort. The trapping of air in the herniated portion of the stomach with spasm at the hiatal orifice causes a sensation of fullness and gaseousness with inability to belch. There is no constant correlation of symptoms to the size of the hernia. Haft and Adler[5] concluded: "In general, the symptoms will depend on the degree of mechanical interference with the function of the herniated viscera; on interference with the function of the diaphragm; on the amount of increased pressure in the thorax causing impairment of the circulation and respiration; and on the severity of anemia."

Diagnosis

On clinical grounds alone, the diagnosis is exceedingly difficult and therefore is frequently missed. Roentgenography and esophagoscopy are the available means for diagnosis, and both should be employed as the one supplements the other. Stenosis, which may consist of a funnel-like narrowing, an abrupt constriction, or a weblike stricture, is determined equally well by either method.

Views from many angles, including the Trendelenburg position, are required to determine roentgenologically the position of the lower end of the esophagus. In order to outline the esophagogastric junction in relation to the diaphragm, roentgenograms made with the patient in the recumbent position are frequently necessary, for in reducible hernia the stomach may assume a thoracic position only when the patient is lying down. Demonstration of gastric rugae above the level of the diaphragm establishes the diagnosis.[4]

The criteria for esophagoscopic diagnosis, as described by Clerf and his associates,[4] include anatomic demonstration of a portion of stomach above the diaphragm, relaxation of the esophageal mucosa and absence of the normal "pinchcock" action at the hiatus. In the experience of these authors, this method was superior to roentgenography in determining the presence of ulceration.

Vague, indeterminate symptoms in the upper part of the abdomen or lower part of the chest should suggest esophageal hiatal hernia. The pain may occur soon after retiring, appearing earlier than the pain associated with ulcer. Increased intra-abdominal pressure from whatever cause may precipitate an attack, and reduction of this pressure by belching or passing flatus, or following an enema, brings relief. Among other diagnostic points mentioned by various authors is aerophagy, for the distention of the stomach by air may reduce the hernia by pulling it down out of the hiatal orifice.[2a]

Differential Diagnosis

Errors in diagnosis are frequent and vary widely. In a series of 404 cases of esophageal hiatal hernia in which the patient was operated on by Harrington,[1a] an average of three erroneous clinical diagnoses had been made prior to establishment of the correct diagnosis. Exclusive of those cases in which multiple lesions were present, there were 35 in the series of 110 cases reported by Clerf and his associates[4] in which there were errors in previous diagnosis. In the order of frequency these included carcinoma, achalasia, duodenal ulcer, coronary thrombosis, cholecystitis, gastric ulcer, indigestion, foreign body, esophageal diverticulum, gastrointestinal hemorrhage, anemia and multiple diagnoses. Among other common errors are cholelithiasis, hyperacidity, cor pulmonale, stricture of the esophagus, appendicitis, intestinal obstruction, mediastinal tumor and hydropneumothorax. In a number of recorded instances tuberculosis had been diagnosed, with treatment carried out for long periods of time in some cases; in 1 such case the correct diagnosis was finally made when an attempted aspiration of the chest produced gastric contents.[5,8]

It is obviously important to differentiate cardiac disease from hiatal hernia. Particularly when surgical procedures are under consideration, a mistaken diagnosis of disease of the coronary arteries presents a serious problem. In order to rule out cardiac disease which might contraindicate surgical repair, the cardiologist must keep in mind this simulation.[4] An illustrative case is that of a 38 year old man which terminated fatally following perforation of an ulcer in the herniated portion of the stomach; operation had been delayed too long because of suspected myocardial infarction.[9] Hiatal hernia should be suspected when there is a history of coronary thrombosis, anginal pain or paroxysmal auricular fibrillation, especially if posture appears to be a precipitating factor.[2a,10a] Gilbert[2a] favored roentgen investigation in every case of angina pectoris if the patient's condition permits, and also in cases of coronary thrombosis if and when the condition of the patient warrants such an examination without interference with the treatment of the cardiac infarction.

In the case reported by Haft and Adler,[5] herniation of the entire stomach into the thoracic cavity perfectly mimicked left ventricular failure. In Reid's case,[11] the correct diagnosis was greatly delayed because of simulation of cardiac infarction. Beckh and Huffman[12] stressed the importance of diaphragmatic hernia in the differential diagnosis of disease of the coronary arteries, and Moschcowitz[13] reported the simultaneous association of this abnormality and coronary disease.

Occurrence of the symptoms at the time of life in which disease of the coronary arteries is prevalent adds to the difficulties of differential diagnosis. Precordial pain radiating to the left shoulder and down the left arm may be the only presenting symptom. Harrington[1c] was of the opinion that this pain is caused by reflex constriction of the coronary arteries mediated through the vagus. On the other hand, Jones and Chapman[10a] held that the pain is mediated over the visceral afferent fibers supplying the esophagus and the cardiac and fundic portions of the stomach or over the sensory afferent fibers from the diaphragm, contained in the phrenic or middle or lower thoracic nerves. They concluded that overdistention of the lower end of the esophagus or herniated portion of the stomach may cause typical anginal pain and cited experiments in which such pain was produced by distention of the esophagus with balloons. Attacks of paroxysmal auricular tachycardia may also be the initial complaint.

A definitely abnormal electrocardiogram has some diagnostic value, but a normal one does not exclude angina of coronary origin. The recumbent position may increase the discomfort of the hernia, but may give relief in angina pectoris. Too, exertion is not so constant a precipitating factor as in disease of the coronary arteries. One third of the patients in Jones' series,[10b] stated that pain was initiated by exertion, but not constantly; a like number obtained relief with nitroglycerin, but in no case as regularly as in true angina of coronary origin.

Report of Case

M. B., a vegetable merchant, was in 1941 at the age of 38 rejected for life insurance because of hypertension at a level of 160 systolic and 110 diastolic. In August 1946, while swimming in the ocean, he experienced sudden sharp, shooting pains in the neck and arms, radiating into both palms and to the finger tips. Since that time, there has been an almost constant painful tingling sensation in the arms and hands, aggravated by use of the arms and interfering with sleep.

In January 1947, a diagnosis of adhesive arachnoiditis involving the cervical portion of the spinal cord was made at the Lahey Clinic. He was unenthusiastically offered and declined a lumbar sympathectomy as possible relief for his hypertension, which at that time was usually in the range of 200 systolic and 120 diastolic.

Except for the neurologic disturbance, the patient remained well and actively at work for two and a half years. On July 31, 1949, he was admitted to St. Vincent's Hospital suffering from severe pain in the chest of six hours'

duration. The pain, which had awakened him from a sound sleep, was compressing in nature and radiated down both arms to the wrist. Profuse perspiration and moderate nausea occurred, but no vomiting.

On physical examination, he appeared acutely ill and in severe pain. The lungs were clear, and there was normal cardiac rhythm. The blood pressure was 124 systolic and 80 diastolic. An electrocardiogram presented a typical pattern of anterior myocardial infarction (fig. 1).

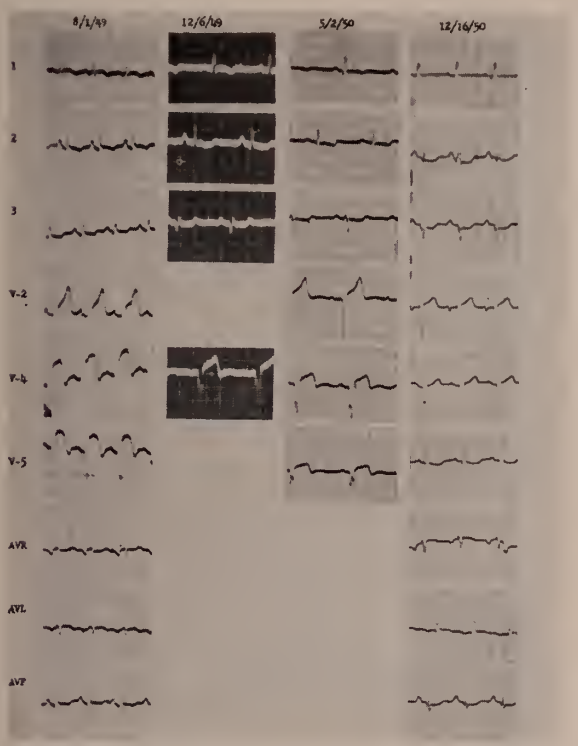


Fig. 1. — Serial electrocardiograms show a typical pattern of anterior myocardial infarction.

Examination of the blood revealed a white blood cell count of 15,300 with 87 per cent neutrophils, 11 per cent lymphocytes and 2 per cent monocytes. Urinalysis showed albumin 1 plus. The sedimentation rate was 112 mm. per hour, subsiding to 16 mm. after eight days.

The patient was placed in an oxygen tent and given injections of morphine to relieve the pain, which persisted intermittently for two days. From the second to the sixth hospital day there was elevation of temperature, the maximum ranging from 100 to 101 F. The remainder of the four week period of hospitalization was relatively asymptomatic, with the exception of a severe attack of urticaria.

On discharge, a roentgenogram of the heart, taken at 6 feet, demonstrated approximately 20 per cent enlargement, especially in the region of the left ventricle (fig. 2).

After two months' convalescence, he again returned to work and remained well until December 12. At that time he again experienced severe pain in the anterior portion of the chest, radiating to both arms and the neck. He became nauseated and vomited his evening meal.

On readmission to the hospital one hour after having vomited about 1 pint of dark blood, he was apprehensive, weak, perspiring freely, and writhing about in bed despite efforts of attendants and members of the family to quiet him. The white blood cell count was 9,400, with 70 per cent neutrophils, 1 per cent eosinophils, 1 per cent basophils, 17 per cent lymphocytes and 1 per cent monocytes. The following day he began hiccoughing continually and continued to do so for five days, until bilateral injection of the phrenic nerve with novocain was performed.

Roentgen study of the upper portion of the gastrointestinal tract revealed a constant deformity of the lower part of the esophagus and of the cardia (fig. 3), which was attributed to carcinoma. Esophagoscopy gave the same clinical impression of malignant disease. The section removed for biopsy from the lower one fourth of the "esophagus," however, was composed of gastric mucosa and benign inflammatory tissue. Following the esophagoscopy, there was prompt relief of distress in the chest, and no filling defect could be demonstrated in the esophagus and the cardia on repeated roentgen examination. A diagnosis of esophageal hiatal hernia was made. After sixteen days, the patient was discharged from the hospital. He was advised to have frequent feedings and to elevate the head of his bed about 16 inches.

In April 1950, while he was on a strenuous business trip to Texas, there developed "heaviness" in the chest, dyspnea and a cough productive of frothy, bloody sputum. He was digitalized, with prompt relief. He remained well, without digestive disturbance, until December 16, when he was again readmitted to the hospital because of "excruciating, burning pain" in the anterior portion of the chest, which radiated to both arms. He had obtained no relief following the use of nitroglycerin sublingually and had shortly thereafter become nauseated and had vomited repeatedly.

On admission, he appeared in moderate shock, was dyspneic and coughed up pink, grossly bloody sputum. Examination of the chest revealed fine moist rales in the lower two thirds bilaterally. He was placed in an oxygen tent. An electrocardiogram gave evidence of extensive myocardial damage, but the pattern did not appear to be



Fig. 2. — Roentgenogram, taken at 6 feet, demonstrates cardiac enlargement and moderate pulmonary congestion on Jan. 15, 1951.

that of recent infarction. On the following day, emesis of approximately 300 cc. of dark, bloody matter and beginning hiccough indicated recurrence of the esophageal hiatal hernia. He was given 50 mg. of methantheline bromide (Banthine) every six hours, ½ ounce of magnesium trisilicate every two hours, and frequent feedings. He was permitted to be ambulatory. In a period of four days the hemoglobin estimation was reduced from 85 per cent to 74 per cent. He was discharged on the seventh hospital day.

Three days later, on December 26, he became acutely dyspneic, and there was clinical evidence of left ven-

tricular failure. Demerol gave temporary relief, and mercurial diuretics have since been employed to keep the chest moisture-free. An ulcer regimen has been instituted to prevent recurrence of symptoms of the hiatal hernia. He has remained relatively comfortable on limited physical activity, and now, in late January 1951, has returned to work for three hours daily.



Fig. 3. — Arrow indicates a portion of the filling defect demonstrated roentgenologically in the lower end of the esophagus and in the cardia.

Treatment

Fortunately, medical management has sufficed in this case and will usually grant symptomatic relief. In the recent series of Clerf and his associates,[4] 69 per cent of the patients received medical and mechanical treatment.

A bland, low residue diet is indicated, and feedings should be small and frequent. As with ulcer patients, emotional upheavals should be avoided. Liquids with meals and postural measures to encourage the passage of foods are helpful, as is the semirecumbent position for sleeping, which prevents gravitational esophageal regurgitation of gastric contents. Reclining after meals is detrimental. Alkalis and antispasmodic preparations to block neurogenic influences are useful.

Patients who are overweight should be urged to a caloric intake low enough to restore normal weight. Reduction of weight is in itself sufficient to relieve the herniation in some cases.

Relief may be obtained for years in some cases by endoscopic procedures, which include dilatation of obstruction and treatment of ulcerations by topical applications.

Although the majority of patients can be treated successfully by conservative measures, surgical repair of the hernia, described in detail by Harrington,[1a] is occasionally necessary. This author advocated the abdominal approach and advised consideration of surgical measures when one third or more of the stomach is involved. Should the colon become involved, surgical repair is necessary because of the danger of intestinal obstruction. Recently, Merendino, Varco and Wangensteen[14] described a method of transferring the esophagogastric junction into a new location and obliterating the hiatus completely.

Summary

The incidence, etiology, symtoms, diagnosis and treatment of esophageal hiatal hernia are reviewed. The difficulties of differential diagnosis are discussed, particularly in relation to cardiac disease.

A case is reported in which recurrent esophageal hiatal hernia and myocardial infarction, with their confusingly similar manifestations, occurred concomitantly.

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Absorbable Postplaced Sutures in Cataract Surgery

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The case for absorbable sutures in cataract surgery is strong, but the case for 6-0 mild chromic sutures placed after the section, using Grieshaber needles is, in my opinion, excellent. An adequate cataract suture should be easy to place, cause no interference with the extraction of the lens, permit point to point approximation, allow quick closure of the wound, promote secure healing of the wound, and be easily removed and nonirritating to the tissues of the eye.

First of all, these sutures are easily placed because of the Grieshaber needles. These needles have one cutting edge on the underside extending back to the midpoint of the 3/8 circle curve on which they are built. The blunt end has an eye through which the suture material is easily threaded. In spite of the presence of the eye, the needle is not bulky at this end. These needles are very sharp and can be used repeatedly, provided the cutting edge is not grasped with the needle holder. To me, they have a distinct advantage over the conventional atraumatic needle.

Good point to point approximation is easily obtainable if one maintains the essential radial direction of the needle. Grieshaber needles allow both corneal and scleral bites to be made in one motion. Little fixation of the cornea is required, thus reducing the amount of trauma to this tissue. Optimum corneoscleral approximation is further enhanced by insertion of the sutures near the extremities of a small knife or keratome section after the manner of Perera.[1] The accuracy in point to point approximation has been brought out in my experience by the prompt reformation of the anterior chamber, the absence of prolapse of the iris, no delayed partial loss of the anterior chamber, and the presence of only an average amount of astigmatism postoperatively.

The 6-0 chromic sutures of the direct corneoscleral type cause no interference with the extraction of the lens. They can be dressed out of the way with ease provided they have been soaked a sufficient length of time in water or in 5 per cent glycerin for five minutes as suggested by Hughes.[2] This type of catgut suture does not stand out well against the usual off white drapes. This disadvantage can be easily overcome by adding several drops of methylene blue to the glycerin solution as recommended by Fralick.[3]

Any adequate cataract suture must allow quick closure of the wound as soon as the lens is delivered. This requirement is fulfilled as well by 6-0 chromic catgut as by the use of silk. Prior to the extraction of the lens the first knot is loosely tied, and as soon as the lens is delivered the loop between the corneal and scleral edges of the wound can be pulled up and this knot tightened. This maneuver can be accomplished in a matter of seconds. Once the first knot is drawn down against the wound, one can then take one's time in tying the second knot, replacing the iris pillars, and carrying out the wound toilet.

The purpose of any cataract suture is to promote quick, secure healing of the wound. The 6-0 mild chromic suture material is admirably suited for carrying out this aim. Fralick[3] has done some interesting studies on cataract wound healing. He has found that the first stage consists of the formation of a fibrin clot which plugs the wound. This fibrin clot accounts for the reformation of the anterior chamber in some cases even before the operation is concluded. Fralick[3] also found that there is a delay of about four days before there is fibroblastic infiltration of this fibrin clot. This latent period is somewhat shortened by the use of sutures that give good approximation of the wound, for good approximation means a small fibrin clot, and the smaller the clot the less distance the fibroblasts must migrate.

The fibroblastic proliferation is fairly secure by the seventh postoperative day, and mild chromic catgut maintains approximation of the wound until this granulation tissue can seal the wound. Any suture, silk or catgut, becomes loose in the wound after five to seven days have elapsed.

Read before the Florida Society of Ophthalmology and Otolaryngology, Twelfth Annual Meeting, Hollywood, April 22, 1951.

The wound is not secure enough in a week for removal of silk sutures. If they are left in longer than this, however, the loosened silk can often act as a wick, thus causing delayed partial loss of the anterior chamber. Although mild chromic catgut is said to be microscopically evident in the tissues for ten days to two weeks, it is seldom grossly evident more than seven days. The Van Lint flap which I employ is usually retracted by the end of seven days, and I have never found any trace of the suture material at this time.

Easy removal is, of course, a prime consideration in the use of any suture because of the possible complications such as rupture of the wound, hemorrhage, prolapse of the iris, or even vitreous loss which can occur during the removal of silk sutures. But with the use of absorbable sutures these pitfalls are avoided.

The degree of irritation from the use of absorbable sutures is a controversial subject. Hughes[2] found that catgut causes somewhat more reaction than silk of a comparable size, but it must be borne in mind that he used 5-0 plain catgut. Since 1944, the quality of the catgut has been improved, and it is now available in the 6-0 size. Fralick,[3] however, was of the opinion that 6-0 mild chromic catgut compares favorably with 6-0 silk. In my experience, I have found absolutely no irritation which can be traced to the suture. So I must conclude that this catgut is nonirritating even when employed as a direct corneoscleral suture.

Summary

I have presented a method of cataract suturing using postplaced mild chromic catgut with Grieshaber needles in which the two slight disadvantages of absorbable sutures, namely, difficult visualization and slight stiffness even after soaking, are far outweighed by the advantages, such as easy placement, good point to point approximation, quick and secure healing of the wound without irritation, and complete absorption, which obviates the necessity for removal.

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Discussion

DR. JOSEPH W. TAYLOR, SR., Tampa: In the last thirty years, volumes have been written about sutures in surgery of the eye, but all these discussions have pertained to the technic used in placing the sutures rather than the material itself. Not very long ago two ophthalmologists were demonstrating their different methods of inserting sutures for corneal transplants, and each gave the suture a name of his choosing. In so far as I could tell, the only difference was that Dr. A began his suture at the nasal and Dr. B. at the temporal side of the cornea.

In the past, general surgeons used nonabsorbable sutures in thyroid surgery, and now most of them are using catgut. The same is true of ocular muscle surgery; the absorbable sutures are replacing the silk or cotton sutures. As the essayist stated, we have seen no undue reaction from this type of suture, but we believe the lack of such reaction is due to the improved mild chromic catgut that we are now using. We also like the Van Lint flap because it gives added protection to the corneoscleral wound and helps absorption of the catgut. So far we have had no delayed partial or complete loss of the anterior chamber occurring several days following the operation.

I should like to reiterate what has been said by my associate, that with the Grieshaber needles the postplaced sutures are easily inserted, the apposition is excellent, and it is a joy and comfort to have them absorb without the trouble and dangers that go with postoperative removal of the nonabsorbable sutures.

It has been my privilege to observe a number of patients at the time of operation, during their stay in the hospital, and at the office later for refraction. Their convalescence has been uneventful; their refractions have shown the minimum of astigmatic error usual in aphakic eyes.

My prediction is that in the near future absorbable sutures will be the choice in cataract surgery.

DR. CHARLES W. BOYD, Jacksonville: I should like to take this opportunity to thank the essayist for the invitation to discuss this timely subject. Up to the first of this year I had read about absorbable cataract sutures and had watched my old professor, Dr. Wendell Hughes of Hempstead, N. Y., use these sutures in his cataract work, but, like most of us, had refused to be bothered with anything different when what I had was working out so satisfactorily.

After accepting the invitation to discuss this paper, I immediately began inquiring as to who was using absorbable sutures. To my surprise I found that there were relatively few surgeons using these delightful sutures that Dr. Taylor advocates.

Procurement of the sutures was simple. I began using them about the middle of January 1951, and what I have to say for and against is the result of observation on 36 cataract cases in my practice to date.

From this experience, I would summarize the advantages as follows:

1. The 6-0 material is excellent, strong, and the needles sharp.
2. The suture slips through the tissue easily and does not bind.
3. The suture ties up tight on the first knot and does not slip.
4. Resolution begins about the fifth day and usually is complete about the tenth day, although in some few cases the sutures are still present on the fifteenth day.
5. Reaction locally is minimal.
6. The apprehensive patient is relieved of the fear of suture removal and the surgeon the danger engendered by the maneuver.
7. The suture can be used, preplaced or postplaced, with or without flap, by employing a slight modification of the technics.

The disadvantages are:

1. The patient complains of more discomfort the first two or three days postoperatively, as a rule, than with black silk, but this is relatively minor.
2. The suture compared to black silk is more unwieldy, that is, it crawls, tangles and refuses to stay put. For the surgeon operating by himself and without trained assistance, I believe black silk is the more satisfactory.

Stress and the General Adaptation Syndrome or The Theories and Concepts of Hans Selye

Joseph G. Seltzer, M.D.
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The past twenty years in medicine have been years of great discoveries, spectacular concepts and wonder drugs. During these two decades, medicine has advanced more than in the past two centuries.

Most of the miracle drugs, such as the sulfonamides, penicillin, and the mycins, utilized freely, and sometimes too freely, resulted from the painstaking work of one man or one group of workers, who carried out their research problems in their one field. The new miracle drugs, ACTH and cortisone, however, evolved from isolated observations, single findings, and a mass of apparently unrelated scientific facts that date back to in and around 1850.

To one man, medicine especially owes a deep debt of gratitude and heartfelt thanks. The concepts and work of Hans Selye have opened new avenues and new fields of thought and research in the everlasting struggle of man against disease and death. Selye's concept that adaptability is probably the most distinctive characteristic of life and his work in correlating all known facts into a unified system have been truly creative.

Since ACTH and cortisone are becoming more freely available, and in view of the fact that utilization of these drugs will be employed in ever increasing amounts, every physician should have a basic understanding of the principles of stress and adaptability.

History

In the middle of the nineteenth century, Claude Bernard realized that to maintain life, the constancy of the body and mind as a whole must be preserved in spite of the changes in the environment. Subsequently, Walter Cannon introduced the term "homeostasis" to designate the maintenance of this steady state and to direct attention to the role of epinephrine and of the autonomic nervous system in bringing about the internal adjustments upon which it depends.

Frank Hartman, an American, purified adrenal cortical extracts. Experiments with these extracts led to the "general tissue hormone" theory of the corticoids. The conclusion reached was that cortical hormone is necessary for the function of all cells, because it raises the resistance of tissues to infection, combats fatigue of muscles and nerves, and maintains a normal temperature and hydration of tissues.

In 1934 Rene Leriche described "post-operative malady," a clinical syndrome accompanied by characteristic blood chemical changes which appeared after all kinds of severe surgical procedures. Other investigators described morphologic, functional or biochemical changes following exposure to drugs, infections, nervous stimuli, trauma and burns. No correlation was suspected between all these scattered observations.

In ancient medical books, physicians long suspected the curative value of pain, starvation and many other damaging agents. These observations, however, were first evaluated scientifically by Wagner-Jauregg. He first utilized the therapeutic action of fever for various mental diseases, particularly general paralysis. This led to research on other forms of nonspecific therapy, "foreign protein therapy," "malaria therapy," and the like. The mechanism by which artificial fever exerted its beneficial effects, however, and the possible relationship between these and the foregoing observations remained a mystery.

Masugi, a Japanese, observed that in animals treated with renal extracts there developed antibodies against kidney tissue. When their nephrotoxic serums were injected into individual animals, they produced nephrosclerosis and malignant arteriosclerosis with hyalinization of the vessel walls, such as is observed in malignant hypertension and certain allergic diseases.

In 1934, Harry Goldblatt described the production of experimental hypertension by the partial constriction of a main renal artery.

In 1936, it was noted that animals exposed to a variety of nonspecific damaging agents responded with a discharge not only of epinephrine but also of adrenocortical hormone. Simultaneously, their resistance to numerous damaging agents was increased. The most striking feature of this response was its extreme nonspecificity. Any stress was apparently met by an increased discharge of corticoids. This observation suggested that perhaps in man also all the systemic diseases, indeed all the stresses and strains of normal life, are met by a similar defensive corticoid production. Thus developed the realization of one of the fundamental adaptive reactions of vertebrate organisms.

In 1937, it was noted that if the hypophysis is removed, animals can no longer respond with any adrenocortical secretion, even when exposed to severe, lethal stress. Simultaneously, the resistance of these hypophysectomized animals fell to extremely low levels. It was concluded that normal exposure to stress causes both damage, namely, shock, and defense, namely, countershock, phenomena. In the absence of the pituitary, manifestations of damage such as gastric ulcers, hypothermia, hypoglycemia and hypotension become even worse, while most of the presumably defensive changes, such as fever, hyperglycemia, hypertension and dissolution of lymphatic tissue, are eliminated.

Thus nature herself has a general defense mechanism in which the production of corticotrophin plays an important part. A promising way to treat the stress factor of disease, therefore, would be to eliminate the physiologic countershock phenomena by administering supplements of ACTH or corticoids when required. It was hoped that by thus supplementing the natural systemic defense reaction, it would be possible to develop a new, and rather universally applicable, approach to therapy.

Several years later, it became evident that, under certain circumstances, increased endogenous production during stress, or exogenous administration of ACTH and corticoids, can, in itself, become the cause of disease, examples being hypertension, arteriosclerosis, diabetes, gout, myocarditis and various rheumatic-allergic conditions. These diseases are due to excessive or abnormal adaptive reactions. These findings led Selye to formulate the theory of the "General Adaptation Syndrome" and of the "Diseases of Adaptation."

Selye correlated numerous unrelated and independently acquired data of many nations and many journals devoted to almost every branch of medicine to enunciate and prove his theory. The main results of Selye's work show that:

1. Any systemic stress elicits an essentially similar syndrome with general manifestations.
2. This syndrome helps adaptation.
3. Adaptation can cause disease.

In the past few years, Hench at the Mayo Clinic proved the important clinical value of potent glucocorticoid hormone and corticotrophin. He demonstrated truly dramatic improvement with cortisone and ACTH. At the same time, Perera and Pines reported that hypertension which can be elicited with desoxycorticosterone in man is abolished by adrenal extract containing glucocorticoids, and that spontaneous hypertension is reduced by cortisone. It was also found that rheumatic and allergic conditions in animals are aggravated by mineralocorticoids and helped by glucocorticoids and that a derangement in steroid metabolism exists in patients suffering from rheumatoid arthritis.

These findings support the farfetched view that the adrenal cortex plays a role in the pathogenesis of the diseases mentioned.

Thus an understanding of the general adaptation syndrome has helped furnish powerful new drugs in the treatment of disease.

Physiology and Pathology of Stress

The main facts are as follows:

1. Various stresses which affect large portions of the body (cold, fatigue, infections and intoxications) produce a number of somatic changes conjointly as a syndrome. These are the involution of the thymicolymphatic apparatus, the appearance of gastrointestinal ulcers, and the enlargement of adrenal cortex with discharge of its hormones, lipids and ascorbic acid.
2. Some manifestations, especially the adrenocortical changes, proved to be useful. There is an increased corticoid hormone production as proved by urinary bioassays; this helps adaptation since adrenalectomized animals are highly inefficient in adapting themselves to a change, unless they receive corticoid substitution therapy.
3. Nonspecific stress, such as exposure to cold, can cause malignant nephrosclerosis, hypertension and pathologic changes

resembling those characteristic of acute rheumatic fever or of allergic tissue reactions.

4. Similar changes of hyalinosis with hypertension can be produced by anterior pituitary preparations or corticoids.
5. Sodium deficiency protects the body against hyalinosis caused by any of the agents mentioned.
6. Protein deficiency protects only against the hyalinosis caused by stress or by crude pituitary extracts, not against that elicited by ACTH or corticoids.
7. In the kidneys of experimental animals exposed to nonspecific stress, pituitary extracts or corticoids, many nephrons assume the appearance of a solid endocrine tissue. This is known as the "endocrine nephron."
8. Using special surgical technic, it is possible to transform the entire kidney having the aspect of a solid endocrine gland. This is known as an "endocrine kidney."
9. The endocrine transformation of one kidney produces nephrosclerosis in the contralateral organ as well as hypertension and hyalinization with inflammatory changes in the arteries and the heart.
10. ACTH or glucoid corticoids exert a beneficial effect in rheumatic-allergic collagen diseases of man.

These are the chief observations from which the concept of the general adaptation syndrome was developed to the point at which it stands today.

Principal Theory Regarding the General Adaptation Syndrome

1. In addition to many specific defense reactions, examples of which are maintenance of constant body temperature, osmotic pressure, and blood pressure, there is an integrated syndrome of closely interrelated adaptive reactions to nonspecific stress itself. This is called the general adaptation syndrome, or G-A-S.
2. The G-A-S does not merely represent a transitory emergency adjustment to the changes in environment, but is an adaptive reaction which comprises the learning of defense against future exposure to stress, and helps to maintain a state of adaptation once this is acquired.
3. The process of adaptation may itself become the immediate cause of disease. These are diseases of maladaptation, and among these are some of the common fatal diseases such as hypertension, rheumatic diseases and the degenerative, or wear and tear, diseases of old age. The psychosomatic syndrome may also belong to this group.
4. Manifestations of passive nonspecific damage are closely intermingled with those of active defense.
5. In all observations concerning the specific effects of drugs, diets, surgery and disease, some manifestations of the G-A-S will be superimposed upon the specific changes caused by the agents under study, since these agents cause some degree of systemic stress.
6. The G-A-S, as the absolutely normal man, is an abstraction which never occurs in its pure form. All agents capable of eliciting this syndrome have some specific actions of their own which they do not share with other types of stress.
7. The pressor action of the kidney can be stimulated directly by corticoids, by corticotrophin and, more indirectly, by stress which stimulates the secretion of corticotrophin.
8. The renal hormones also have an action upon protein metabolism, as indicated by hyalinosis and fibrinoid degeneration, particularly in the cardiovascular system.

The Alarm Reaction is defined as the sum of all nonspecific phenonema elicited by sudden exposure to stimuli which affect large portions of the body and to which the organism is quantitatively or qualitatively not adapted. Some of these phenonema are merely phases and represent signs of damage or "shock." Others are manifestations of active defense against damage. In the event of moderately severe systemic stress from which recovery is possible, the signs of injury usually precede the appearance of defense phenonema. Alarm reaction may, therefore, be subdivided in turn into two more or less distinct phases.

(1) The Phase of Shock: This is characterized by hypothermia, hypotension, depression of the nervous system, decrease in muscular tone, hemoconcentration, deranged capillary and cell-membrane permeability, generalized tissue breakdown, hypochloremia, hyperkalemia, acidosis, a transi-

tory rise followed by a decrease in blood sugar, leukopenia followed by leukocytosis, eosinopenia and acute gastrointestinal erosions. A discharge of epinephrine, corticotrophin and corticoids is an early defense reaction, which begins during the succeeding phase but is actually characteristic of countershock. The shock phase may vary from a few minutes to about twenty-four hours, depending upon the intensity of the damage inflicted, but unless death ensues, it is always followed by the countershock phase.

There is no satisfactory definition of shock. The definitions that exist are not satisfactory because under certain conditions any one of the so-called "characteristic signs" may be manifested, examples being hypothermia, hypotension, hemoconcentration, capillary permeability, and depressions of the nervous system, although there is no shock; and conversely shock may develop in the absence of such signs.

Selye considers shock as a condition of suddenly developing, intense, general damage. Shock is always a rapidly developing condition. Damage caused by chronic ailments cannot be thus described. Shock also implies that the damage is systemic or general. Localized lesions, no matter how severe, are not designated as shock, unless they lead to generalized damage.

Shock is always considered as primary or secondary. It has been claimed that primary shock is due to nervous stimuli and secondary shock is the result of intoxication with endogenous substances. This conclusion is not definitely proved, and the distinction is not as sharp as was first assumed. Furthermore, even in the event of exposure to stressers which lead to fatal shock within less than an hour, the pathologic and biochemical changes may be practically the same as those occurring in secondary shock. It is therefore doubtful whether these two types should be considered as essentially different, or as an acute and a delayed form of the same process. The data to date suggest that reversible and irreversible shock are due to a difference in severity.

(2) The Phase of Countershock: This phase is characterized by phenonema of defense against shock. There is an enlargement of adrenal cortex with signs of increased activity, acute involution of the thymicolymphatic apparatus and, generally speaking, the reversal of most of the changes seen during the shock phase, namely, rise in blood pressure, hyperchloremia, hyperglycemia, rise in blood volume, alkalosis, increased diuresis and often hyperthermia. These changes are not only synchronous with the stimulation of the adrenocortical activity, but are largely dependent upon the discharge of corticoids into the blood. Countershock phenonema may explain cases in which a distinct period of "primary shock" was followed by secondary shock after an intermittent state of relative well-being.

The countershock phase of the alarm reaction represents a transition to the stage of resistance, and imperceptibly merges into the latter in the event of chronic exposure.

When the alarm reaction was first described in 1936, it was known only that the organism responds with the same set of symptoms to a great variety of systemic stresses. The term "alarm reaction" was coined to intimate that this response represents a call to arms of the body's defense forces. This term, however, has also been used to describe nervous phenonema whose relationship to the general adaptation syndrome is questionable.

The "state of resistance" represents the sum of all nonspecific systemic reactions elicited by prolonged exposure to stimuli to which the organism has acquired adaptation. It is mainly characterized by an increased resistance to the particular stimulating agent to which the body has been exposed and a decreased resistance to other stimuli. Thus the impression is gained that during the stage of resistance, adaptation to one agent is acquired at the expense of resistance to other agents.

Most of the morphologic and biochemical changes of the alarm reaction disappear during the stage of resistance, and indeed in some instances the direction of the deviations from the normal are reversed, that is, hypochloremia during the A-R, hyperchloremia during the state of resistance; loss of lipids from the adrenal cortex during the A-R, deposition of lipids into this gland during the stage of resistance.

The "stage of exhaustion" represents the sum of all nonspecific systemic reactions which ultimately develop as a result of prolonged overexposure to stimuli to which adaptation has been developed but could no longer be maintained.

Selye found that even a perfectly adapted organism cannot indefinitely maintain itself in the state of resistance. If exposure to abnormal conditions continues, adaptation wears out, and many lesions characteristic of alarm reaction, such as gastrointestinal ulcers, and loss of adrenal lipids,

reappear as a stage of exhaustion develops and further resistance becomes impossible.

Conclusion

The great work regarding stress is in the process of extension, and its full meaning is impossible to summarize now. It appears that a multiplicity of host reactions in illness, including the articular and febrile elements of rheumatic fever, the joint involvement of rheumatoid arthritis, the cutaneous and systemic elements of lupus erythematosus, the disturbances in the remainder of the collagen diseases, the bronchospasm, the urticarias, the allergies and numerous other obscure manifestations of illness, may be ameliorated or abolished by suitable adrenal or pituitary agents. These signs and symptoms often recur in varying rates when treatment is stopped, so that cure may not occur. No elimination of a bacterial or viral agent of disease has been accomplished. The mechanisms of relief are complex and probably vary from situation to situation, but modifications of connective tissue reactivity seem important factors. These concepts outlined by Selye emphasize the possibility of deranged pituitary-adrenal functions relating to unexpected systemic consequences.

Disease consists of two components, damage and defense. Up to now, medicine has attempted to attack for the most part only the damaging pathogen, namely to kill the germs, to excise tumors, and to neutralize poisons.

As regards defense, medicine has related itself to such advice as diet, rest, vacations and change of environment. A study of the general adaptation syndrome suggests that we may be able to utilize more effective means of adding adaptation to nonspecific local or systemic injury by supplementing the natural defensive measures of the general adaptation syndrome whenever these are lacking.

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Aerobiologic Survey of the Miami Beach District Report of Pollen Counts for 1948 and 1949 Including Mold Spore Counts for 1949

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MIAMI BEACH

Miami Beach consists of 30 islands mostly man-made from old mangrove swamps and pumped in from bay bottom. The entire area covers 17 square miles including 9 square miles of water. The average temperature throughout the year is a mild 75 degrees. The winter months average 68.2 degrees and the summer months 81.2 degrees. Winds are about 10 miles an hour more or less, usually from the southeast. Miami Beach is located near the southeast end of Florida, 300 miles farther south than any city on the southern boundary of the United States above the Florida peninsula. It is located on latitude 26 north, which is the same latitude as the Southern Sahara Desert, Middle India and Canton, China. The latest population figure is 45,541, and an estimated one million people spend some time in the 371 hotels each year.

Nichol and Durham[1] reported a survey in 1931 showing the scarcity of pollen in the Miami area. Since then this area has become increasingly popular as a haven for hay fever sufferers. Many settled here and helped to build up the community. Certain persons noticed a gradual return of their allergic symptoms after two or more years of apparent cure. It was necessary to obtain up-to-date information to see if there might have been a

Read before the Florida Allergy Society, Third Annual Meeting, Hollywood, April 22, 1951.

change in the pollen pollution of the air. With this in mind an aerobiologic study was started in September 1947.

Technic

A standard pollen trap was placed on the top of the three floor Alton Road Hospital. There were few pollen grains on the slide in twenty-four hours even when an area of 8.8 sq. cm. was examined. Exposing the slide for longer intervals resulted in the collection of more pollen and made the count more accurate. During 1948 slides were exposed for forty-eight to seventy-two hours and weekly during 1949. The slides were stained with Calberla's solution, and all pollen granules over a slide area of 4.84 sq. cm. were counted under the low power. The high power objective was used frequently to aid in identification. The counts are reported in grains per square centimeter. An effort was made in this study to note the seasonal variations of the pollen.

Trees

Australian pine is shown in table 1. The tree is used for ornamental or hedge purposes throughout Miami Beach and South Florida. One definite pollinating season was noticed starting in February and ending in May or the first week in June. More Australian pine pollen is present by far than all other pollen put together.

Table 1.—Australian Pine Monthly Pollen Counts

	1948	1949	1950
Feb.	101	133	90
Mar	35	37	139
Apr.	3	40	88
May	31	2	24
June	2	1	0
Total	172	213	341

A previous report by Zivitz[2] in 1942 showed the peak of pollination during April 1940 and 1941. In my survey the highest counts occurred in February 1948 and 1949 and March 1950. During February 1948 Australian pine pollen appeared on 16 days for a total of 101 grains. The highest number on a single day was 20 grains, or 40 grains per cubic yard using two as a factor. The daily average for February 1948 was 13 grains per cubic yard and for the season, 6 grains per cubic yard.

The daily average during February 1949 was 15 grains per cubic yard. The daily average for the 1949 season was again 6 grains per cubic yard. The pollen trap was moved to the roof of the six floor Mt. Sinai Hospital in January 1950. Frequent rains during February prevented heavier pollination, and the high counts occurred in March 1950. The highest count was 34 grains per cubic yard, and the average for the season was 8 grains per cubic yard.

Pollens of the other trees were seen in small amounts from the oaks, regular pines and the junipers. During March 1950 the pollen of Juniperus virginiana (red cedar) was seen for two weeks.

Grass

Bermuda grass, Johnson grass and Natal grass are the only ones of importance in this area.[4] No attempt has been made to identify the different varieties of grass pollen. The distribution of grass pollen during 1948 and 1949 is shown in table 2. There were only 65 grains during 1948, and a total of 81 grains during 1949. This means that only a small fraction of 1 grain per day was the average through the year. Even with multiplication by the factor two, which is the factor for grass pollen recommended by Durham,[3] the result would be less than 1 grain per cubic yard.

Table 2.—Grass Monthly Pollen Counts

	1948	1949
Jan.	1	0
Feb.	5	6
Mar.	9	0
Apr.	5	20
May	26	16
June	10	16
July	2	5
Aug.	2	7
Sept.	2	5
Oct.	0	3
Nov.	1	3
Dec.	2	0
Total	65	81

Compare some grass pollen figures from other localities: Los Angeles 232; Tucson 334; Washington, D. C. 366; Key West 224 and Orlando 1,832. I wish to emphasize that the figures for grass pollen in this area are extremely small in comparison. It was truly amazing to find such small counts for two years in succession. Between March and June 1948 only 40 grains of grass pollen were seen on 58 days, an average of 1.4 grains per cubic yard on the pollinating days. In 1949 between April and June a total of 52 grains was seen on 84 pollinating days for an average of 1.2 grains per cubic yard. From August to December of both years this area was practically free of grass pollen. It would appear from these figures that symptoms would be caused by strictly localized exposure and not general.

Ragweed

An area of 4.84 sq. cm. of slide was always examined before reducing to 1 sq. cm. This was necessary because the ragweed pollen frequently occurred clumped together, and it would have been easy to miss all the ragweed. For the entire ragweed season (table 3) from June to September 1948 there were 24 grains found on 25 pollinating days, an average of 1 grain per day or 3.6 grains per cubic yard. The average for June 1948 was a little higher than for the other months. In 1949 the ragweed pollen appeared only from May to August and again in November. The total number of grains was 53 for the entire year. The highest daily average occurred in November, amounting to 3.6 grains per cubic yard. The average for the pollinating days was about 2 grains per cubic yard.

Table 3.—Ragweed Monthly Pollen Counts

	1948	1949
May	0	14
June	13	9
July	4	5
Aug.	4	3
Sept.	3	0
Oct.	0	0
Nov.	0	22
Dec.	0	0
Total	24	53

By comparison with other Florida localities it can be seen readily how favorable this area is for the ragweed patient. In 1949 Key West reported 20 grains and Orlando 471 grains. The Florida State Board of Health established a number of stations during 1950. Daily counts were made, and the following total counts were reported: Miami Beach 8, St. Petersburg 34, Melbourne 340, Daytona Beach 40, Jacksonville 91 and Orlando 998. The Health Department's pollen station in Miami Beach was located in the same general vicinity as mine, but within two blocks of the ocean. It is possible that the ocean breezes prevented the ragweed pollen from settling there. This observation would indicate that ragweed patients should be near the ocean during the summer months.

The survey showed: (1) There was a definite ragweed season from May to September, which was longer than in Northern areas. The presence of ragweed in November 1949 may have resulted from unusually strong westerly winds. (2) Patients encounter slightly more ragweed pollen than grass pollen. (3) The ragweed index during August, September and October is almost zero and is just about as nearly perfect for ragweed hayfever sufferers as any place could be.

Molds

No attempt was made to identify the different varieties of mold spores or fungi except to note the preponderance of short spores over long ones. The long spores refer to Alternaria and kindred spores, such as Cephalothecium, Spondylocladium and Helminthosporium, whereas the one and two cell spores refer particularly to Hormodendrum. Table 4 shows the distribution of the fungus spores. Alternaria and Helminthosporium have been seen in small numbers throughout the twelve months. Spondylocladium and Cephalothecium have been encountered less frequently. A Tetraploa spore was found on several occasions. The Hormodendrum spores are oval and much smaller than Alternaria. They are deposited in large numbers on the slide. Hormodendrum and Cladosporium are considered by some mycologists to be identical; others classify Hormodendrum as being one-celled, and Cladosporium as two-celled.[5]

Petri plates containing a special mold-growing medium were exposed for twelve minutes to the outdoor air at the Mt. Sinai Hospital. After exposure the plates were incubated at room temperature until the colonies reached maturity. Then each macroscopically different colony was transferred to a tube slant. When growth was seen, the tubes were sent for identification to Professor Christensen at the University of Minnesota. This brief survey revealed the following mold colonies: Alternaria, Hormodendrum, Nigrospora, Helminthosporium, Phoma (two different species), Plenozythia, Spondylocladium, Actinomyces or Streptomyces, and one unidentified species.

Table 4.—Monthly Mold Spore Counts

	1949 Long Spores (Alternaria and Kindred Spores)	1949 Short Spores (1 and 2 cell Spores-Hormodendrum)
Jan.	2	0
Feb.	2	0
Mar.	17	0
Apr.	2	0
May	5	300
June	23	200
July	14	400
Aug.	6	400
Sept.	4	200
Oct.	4	600
Nov.	6	400
Dec.	15	0
Total	100	2,500

The subject of molds in relation to inhalant respiratory allergy has become recognized by physicians. The problems to be solved are (1) the relation of the mold spore population of the air to patient symptoms and (2) whether or not seasonal variations are present. The spores therefore would come into the "potential" category with respect to allergenic significance in inhalant respiratory disease judging from the high counts of "one and two-celled spores." It is possible that some of the natives have become sensitive to the air-borne spores for the following reasons: (1) Symptoms of respiratory allergy appear in the fall months and continue into the winter. (2) They show positive skin reactions to mold extracts. (3) No other air-borne contaminants can be incriminated.

Conclusion

A survey based on the examination of exposed slides over a two year period reveals these facts:

1. Grass pollen is insignificant.
2. Ragweed pollen is scarce and almost completely absent during August, September and October, making this district a perfect haven for ragweed patients.
3. Australian pine has a definite pollinating season and produces a large quantity of pollen.
4. This is the first report of the spore population of the air in this district. For some air-borne molds there is a "season" which is reflected in patients' symptoms, but for others this is not indicated.

Appreciation is expressed to Prof. Clyde M. Christensen for identifying the mold colonies.

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Changes in Compensation Law

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For years it has been realized that recent graduates of medical schools, as well as those who have completed their internships and residencies, enter into the practice of medicine with little or no knowledge of the medicolegal problems involved in the treatment of the injured workman as affected by the Workmen's Compensation Law. The books entitled "Disability Evaluation," by McBride, and "Accidental Injuries," by Kessler, are of definite benefit, particularly to the novice, but in no way are they a complete answer to the problems that confront the practitioner.

The medical schools, as well as the staffs of the hospitals where the graduates serve their internships and residencies, should institute some means of instruction regarding this subject, such as a formal course, providing certain basic facts of training to those entering practice, in order that the problems with which they will be confronted may not be so baffling. At this time a knowledge of the compensation law is important indeed, particularly in view of the recent changes made by the last state legislature.

Prior to July 1, 1951, an injured employee, who had been away from work four days as the result of his injury, was then legally entitled to 60 per cent of his average weekly salary, having as a basis a maximum of $22 per week and a minimum of $8 per week, which he would be paid. In other words, if the injured had been receiving $100 a week salary and became disabled, the most he could expect to receive would be $22 per week or a minimum of $8 per week during his period of temporary total disability. The recent changes in the law by the legislature now entitle the injured employee to receive $35 per week instead of $22 and the $8 per week minimum allowance is still maintained.

While most injured employees are anxious to return to their work, there still remains an indolent minority among them, who are willing to accept a pittance for existence. It, therefore, would appear to be much more difficult in the future to return such an employee to his work as long as he is receiving the weekly income of $35, particularly when, in addition, this sum is complemented by

the various industrial private insurance policies that he may carry.

An employee who now, by reason of an injury, becomes permanently totally disabled will receive continuous payments for a period of seven hundred weeks at the maximum rate of $35 per week, this being equivalent to $24,500, increasing the maximum sum over 300 per cent above that provided prior to July 1, 1951. In case of death as the result of injury, the benefits going to dependents still are provided for a period of three hundred and fifty weeks, which, at the new rate of $35 per week, are equivalent to $12,250, compared to $7,700 previously. The striking feature in the change of the law is that the final evaluation of the permanent partial impairment of an injured employee in the future must be carefully guarded owing to the fact that the maximum weekly benefits have been increased from $22 to $35.

I am of the opinion that throughout the state those who are involved in passing professional opinion on the final evaluation of the permanent partial impairment of an injured person have been somewhat liberal in the indefinite cases, particularly cases of low back involvement, in granting a permanent partial impairment on a nuisance basis. Frequently this amounted to 10 per cent of the body as a whole. Today, such allowance without a true basic medical background would be prohibitive.

Because of the legislative changes, liberal in character, insurance rates on compensation insurance are bound to increase in order to offset the cost of compensation benefits. In fact, there already has been a 15 per cent increase in rates. Most any insurance company will claim that the carrying of compensation insurance is not desirable and is done only in order to secure other types of business of more profitable nature. It is conceivable that many companies may discontinue their business in Florida entirely, it now being one of the most liberal of all the states. In fact, I am informed that two have already taken such action.

In turn, the estimate of permanent partial impairment of an employee now must receive far more careful attention than previously and should be based upon medical fact entirely, without regard to the nuisance value. Likewise, in order for the medical profession to keep faith with the public and with the industrial courts and insurance companies, every estimate of permanent partial impairment should be purely on a medical basis with only the element of human error entering into the variance in percentage of the individual estimators. Wide variances in percentage estimates of permanent partial impairment by physicians only lead to distrust of the profession as a whole.

These are a few of the major features of the changes. If at each state convention or even the district meetings an instructional course or a conference were held with a question and answer hour regarding the interpretation of the various phases of the compensation law, as applied to the practice of medicine, much benefit could be derived and many differences of opinion avoided. All increased benefits assumed by the insurance companies are eventually passed on to the employer in the form of increased rates. The employer in turn passes the increase on to the consumer, and it is absorbed in the cost of the materials which the consumer purchases.

The recent radical liberal changes, no doubt, will create a great incentive among the employers to institute pre-employment physical examinations in order that they may avoid being saddled with the responsibility of financial payment for previously existing physical impairment. The examiner should lend an unreserved effort to make a fair evaluation of the patient's condition and disability, and if there is any doubt in his mind, the benefit should be given to the injured.

It must be remembered that one of the most vulnerable areas of any person is his purse. The doctor must be prepared to understand that the injured rarely thinks his estimate of permanent partial impairment is enough, and often the insured thinks it too liberal. This differing viewpoint may result in ill feeling of either of the principals toward the surgeon. The doctor then must make liberal self application of that reliable and everlastingly soothing balm composed of the knowledge that he has scientifically, conscientiously and free from influence, given an honest opinion, even if wrong.

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ABSTRACTS OF MEDICAL ARTICLES

THE NORMAL CEREBRAL ANGIOGRAM. By Robert W. Curry and George G. Culbreth. Am. J. Roentgenol. 65:345-373 (March) 1951.

The normal angiographic anatomy of the cerebrovascular system is discussed in detail in this well illustrated article. As in other vascular systems, the courses and distributions of the cerebral vessels present considerable variation. Since some of the variations follow patterns similar to those produced by pathologic change, the authors stress the importance of establishing a thorough knowledge of the limits of normal cerebrovascular anatomy if serious errors are to be avoided in the interpretation of angiographic films. Some of the more important vascular variations which may be seen in cerebral angiography are described.

The observations of normal angiographic anatomy were made from the films of 50 patients who had no space-occupying intracranial lesion that could be determined by history, physical examination, and subsequent clinical course. This series of 50 patients was selected from a total of 210 patients who had cerebral angiography performed at The Johns Hopkins Hospital over a sixteen month period. Pneumoencephalography or ventriculography was performed in 66 per cent of these patients and revealed no significant abnormality. The majority of the patients had either idiopathic epilepsy or subarachnoid hemorrhage of undetermined etiology.

In this series, percutaneous puncture of the common or internal carotid artery for carotid angiography, or of the vertebral artery for vertebral angiography, was carried out following infiltration of the skin of the neck with 1 per cent procaine. The article is intended to be of benefit to those who are confronted with problems in the interpretation of cerebral angiograms. The authors reiterate in conclusion that normal variations frequently simulate changes produced by pathologic processes and unless they are continually borne in mind mistakes in interpretation may easily be made.

GASTRIC RESECTIONS AND VAGOTOMIES, MORBIDITY AND MORTALITY IN A GENERAL HOSPITAL, NOT ASSOCIATED WITH A TEACHING CENTER. By Joseph S. Stewart, M.D. Am. Surg. 17:202-208 (March) 1951.

This study was undertaken in order to compare the results following subtotal gastrectomy and vagotomy as performed in the various teaching hospitals and private clinics with those performed in a general municipal hospital not associated with a medical school, with no full time surgeons and with a staff not tightly closed. A series of 120 cases of subtotal gastrectomy and 17 vagotomies performed at Jackson Memorial Hospital, a municipal general hospital of 500 beds, ward and private, in Miami is presented, and the recent literature on the subject is reviewed.

In the author's series there was a mortality rate of 10 per cent for the 120 subtotal gastrectomies performed by 22 surgeons in a five and one-half year period; for the 17 vagotomies there were no deaths. These results, the only ones reported from a general municipal hospital, are compared with the results in other series. Dr. Stewart suggests that in attempting to evaluate and compare any two procedures, the surgical mortality and morbidity are of primary importance, especially when a benign condition such as duodenal ulcer is under consideration. He recommends, therefore, that each surgeon give careful consideration to his individual mortality and morbidity rates following both subtotal gastrectomy and vagotomy for duodenal ulcer, as well as an accurate appraisal of end results. His conclusions are:

The mortality rate following subtotal gastrectomy, in the hands of the most experienced, is about 3 per cent. It is probable, however, that the rate in many general hospitals throughout the country is many times as high.

The mortality rate following vagotomy has, up to the present, proved to be less than 1 per cent, and it is possible that this rate will not show significant rise even when the operation becomes more widely used.

ADENOMYOMA OF PYLORUS SEEN AT AUTOPSY TWO YEARS AFTER OPERATION FOR PYLORIC STENOSIS IN A NEWBORN GIRL BABY. By Frederick J. Waas, M.D., F.A.C.S., Bernard J. McCloskey, M.D., and Edward J. Sullivan, M.D. Am. Surg. 17:844-848 (Sept.) 1951.

A case is reported in which a 2 year old white girl died suddenly of pulmonary embolism. At autopsy, the pylorus was found to contain an adenomyoma, a tumor containing heterotopic glandular elements surrounded by bundles of smooth muscle. This case presents the rare situation of adenomyoma of the pyloris with symptoms simulating those of the rather frequent hypertrophic pyloric stenosis. Two years previously, at the age of 4 weeks, the patient had been operated on for pyloric stenosis after vomiting had resisted treatment for three weeks. The gross description of the pylorus as observed at autopsy corresponded with the pylorus as described in the surgical record.

It is concluded that the adenomyoma existed at the time of the Fredet-Rammstedt operation and was the cause of the vomiting, also that the symptoms were relieved by the operation up to the time of death two years later. The authors regard the adenomyoma as in no way related to the child's sudden death and they recommend biopsy of every nodular swelling of the pylorus.

SOME LESIONS OF BRONCHI AND ESOPHAGUS. By Thomas M. Edwards, M.D. Laryngoscope 61:-368-371 (April) 1951.

The role of the endoscopist in cooperation with the thoracic surgeon is presented in this paper, which reviews the work of a practicing otolaryngologist and a practicing surgeon in a small to medium-sized city. The growing practice of thoracic surgeons to do their own endoscopy is deplored as disadvantageous to the smaller communities because it does not allow the endoscopist the necessary volume to insure the proficiency required to handle the diagnostic and foreign body work of these communities.

Of the diseases encountered, acquired bronchiectasis occurs most frequently. Malignant disease of the lung, particularly bronchogenic carcinoma, is observed with ever increasing frequency. Diagnosis of pulmonary tumors is one of the most difficult. Purulent tracheobronchitis, especially in small children and infants, is too infrequently treated endoscopically in the author's opinion, and he has had too little opportunity to treat asthmatic patients endoscopically to be able to make a critical evaluation. He also mentions tuberculous and esophageal lesions, foreign bodies, the still too frequently seen lye burns, and cardiospasm or achalasia.

Dr. Edwards stresses the responsibility resting upon the otolaryngologist doing endoscopy in the smaller cities to emphasize and re-emphasize to his fellow practitioners, particularly to the general practitioner, the need for the careful examination by every possible means of the "little cough," or the "little heartburn," and the "mild retrosternal pain." Only in this way is there hope for raising the statistical average of cures from malignant diseases of air and food passages.

ACUTE SUPPURATIVE BRONCHITIS AND BRONCHIOLITIS IN CHRONIC PULMONARY DISEASE: DIAGNOSIS AND MANAGEMENT. By Leonard Cardon, M.D., F.A.C.P., Louis Lemberg, M.D., and Regina S. Greenebaum, M.D. Ann. Int. Med. 34:559-591 (March) 1951.

The pathology and pathologic physiology, clinical picture, diagnosis, treatment and complications of acute suppurative bronchitis and bronchiolitis superimposed on chronic pulmonary disease are discussed in detail, and 8 illustrative cases are reported. The authors conclude:

An episode of acute bronchitis ingrafted on chronic asthmatic bronchitis and emphysema, pulmonary fibrosis or bronchiectasis, often misdiagnosed acute left ventricular failure or pneumonia, may so obstruct the bronchi that an acute respiratory emergency and death by suffocation may be precipitated.

The essential therapeutic measures are: repeated aspiration of the tracheobronchial tree, administration of oxygen in adequate concentration, and the use of bronchodilator, vasoconstrictor, antibiotic and chemotherapeutic agents. Supportive and stimulant measures and the prevention and treatment of complications are important adjuvants.

Even a mild infection of the upper part of the respiratory tract in patients with chronic pulmonary disease must be treated seriously from its very incipience. If progress is unfavorable, early hospitalization for constant observation and early drastic treatment are imperative.

Residence in a warm, dry climate during the late autumn, winter and early spring is valuable in the prophylaxis of this serious asphyxial disease.

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January Anniversaries

JANUARY 6. Percival Pott, a name entirely devoid of euphony and beauty, has become beautiful because of the fine character and high integrity of the man to whom it belonged. Born in London on Jan. 6, 1713, Dr. Pott, the most distinguished surgeon of his period, spent much of his life fighting quackery, which was unusually rampant during his lifetime. Two notorious quacks with tremendous popularity were objects of his wrath. One prevailed upon Parliament to pay £1,000 or more for her remedy for stone—a mixture of snails, eggshell and herbs. The other, a Mrs. Mapp who called herself a bonesetter, was accustomed to ride from Epsom to London in her coach with four liveried servants. During one of his highly articulate and none too tender crusades, Dr. Pott characterized her as an ignorant, illiterate, drunken, female savage.

After sustaining a compound fracture of the leg when he was thrown from his horse, Dr. Pott used the period of enforced leisure to record his medical observations on fractures. Today, every advanced medical student can describe Pott's fracture. An even greater contribution perhaps was his description of what is known now as Pott's disease of the spine.

Dr. Pott was genial, witty and popular. It was said of him shortly before he died in 1788 that he had served St. Bartholomew's Hospital "as man and boy for half a century," but the truth is that he was happiest in his own large family. He had four sons and four daughters.



Percival Pott (1714-88)
Courtesy, Garrison: An Introduction to the History of Medicine, Philadelphia, W. B. Saunders Company.

January 17. Benjamin Franklin was beyond doubt a genius, but at the same time he was a simple, unpretentious American. Born in Boston on Jan. 17, 1706, he became what we may call the first really ideal American in the sense that we think of our nation as made up of people primarily resourceful, inventive, tolerant, loyal, honest and forthright. Franklin was all these and much more. The outstanding citizen of America in the eyes of the world at large, he was also a scientist in the true sense of the word, inventor of the lightning rod and a new type of stove, first editor, publisher and bookseller in Philadelphia, organizer of that city's fire department, founder of the American Philosophical Society, president of the Commonwealth of Pennsylvania and first United States Minister to France.



FRANKLIN

By David Martin (1737-1798). This so-called "thumb portrait" was commissioned by Franklin in London in 1767 for his family. At his death he bequeathed it to the Executive Council of Pennsylvania.

Reproduced through the courtesy of Pennsylvania Academy of Fine Arts.

To Franklin's many-sided genius, medicine owes the invention of bifocal lenses, a flexible catheter, electrotherapy and observations upon gout and medical education. His discovery of bifocal spectacles lapsed into obscurity for many years. He made them by having the lenses of two pairs of spectacles, one for reading and the other for distant vision, cut in half and the half of the one cemented to the half of the other. He wrote from Paris that the bifocals were especially helpful at the dinner table. He was able to see what he ate and also to watch the faces and lips of people on the other side of the table so that he could better understand the French conversation of his hosts.

In his newspaper, by personal solicitation and by petitioning the assembly, Franklin assisted in raising funds for the Pennsylvania Hospital of Philadelphia, the oldest institution in the United States for the care of the sick. "I do not remember," he said, "any of my political manoeuvres the success of which . . . gave me more pleasure."

Everyone would do well to read and reread Franklin's autobiography, his almanac and some of his letters. His words are as alive and valuable today as when he first wrote them. Although Franklin was not a Doctor of Medicine, we of the medical profession acknowledge the valuable contributions of this great American pioneer to the science of medicine.

The Challenge of 1952

Now that the holiday season has waned and the dying old year has made way for the New Year, bright with hope, it seems appropriate to contemplate the priceless gift proffered every citizen across the years by our forefathers. It was they who wrote into our Declaration of Independence: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain inalienable rights, that among these are life, liberty and the pursuit of happiness."

Truly these are pregnant words in our great country today when we stand, as never before in our history, at the crossroads. This concept of liberty, of freedom, of the rights of the individual, is sorely threatened. This precious gift calls for all out defense. The decisions of 1952 may well rock civilization to its very foundations.

Individualist that he is, the physician is peculiarly endowed by the very nature of his profession to appreciate the true worth of his "inalienable rights." Already he has been called upon to take over the front line trenches in their defense and has not been found wanting. But to win a battle is not to win a war.

Addressing the annual convention of the American Legion in Miami last October, Dr. Elmer L. Henderson, immediate past president of the American Medical Association and of the World Medical Association, congratulated the veterans on being one of the first great national groups to go on public record in opposition to compulsory health insurance and any other form of government regimentation and oppression in the practice of medicine. He reminded them that the Legion since 1945, when it first voiced its attitude, had consistently renewed its pledge of opposition, thereby giving evidence in one more way of its devotion to 100 per cent Americanism.

In conclusion, Dr. Henderson expressed the challenge of 1952 in these words:

"Today it is imperative that we all be alert to well camouflaged assaults from the flanks or from the rear. I can assure you without reservation that the medical profession is not dropping its guard. . . .

"We men of medicine are dedicated to the saving of human life. Now we have further dedicated ourselves to the preservation of the American way of life."

Eyes Urgently Needed

The urgent need for eyes is stressed in an appeal by The Eye-Bank for Sight Restoration, Inc., of New York. Since the establishment of this organization in 1945, the demand for eyes for the corneal transplant operation has steadily increased. At first it was believed that possibly 50 eyes a year might meet the need in a city the size of New York, but the Eye-Bank rapidly took on a national character. Not only does it now supply eyes for patients within the city of New York and the surrounding area, but it also supplies most of the eyes to physicians throughout the country who perform the corneal transplant operation.

Each year more and more ophthalmic surgeons are being trained in the technic of performing this operation. Also, owing to advances along technical lines, it has been found that many more patients can be subjected to keratoplasty than was at first supposed. Furthermore, the demand for more eyes is increased today because keratoplasty now has additional uses. It is employed in the treatment of certain corneal diseases as well as in corneal scarring. Particularly is lamellar keratoplasty proving a useful procedure.

The Eye-Bank especially desires that physicians who are enucleating eyes in which the cornea is in good condition report in advance that they plan enucleation so that directions may be given for transporting the eyes to the Eye-Bank. A free pathologic examination of these eyes is made, and reports are furnished.

With widespread cooperation of physicians, it is believed that the demand, which now exceeds the supply, will be met. Those wishing to aid in this program may obtain a description of the eyes suited for keratoplasty by writing or telephoning to The Eye-Bank for Sight Restoration, Inc., 210 East 64th St., New York 21, N. Y., telephone, Templeton 8-9200.

Accreditation of Hospitals by Four Group Commission

A joint commission recently has been established for the accreditation of hospitals in the United States and possibly Canada. It will be composed of 18 members, six appointed by the American Medical Association, six by the American Hospital Association, three by the American College of Surgeons and three by the American College of Physicians. If the Canadian Medical Association accepts an invitation to participate, it will appoint one representative and the American Hospital Association will appoint an additional member from the Canadian hospitals. It is expected that the commission will be in operation by Jan. 1, 1952.

For more than a quarter of a century the American College of Surgeons has successfully administered the hospital standardization program, its investment from membership dues exceeding $2,000,000. It is estimated that the combined budgets of the new commission's constituent organizations, determined on a basis proportionate to representation on the commission, will approximate $250,000 annually, once it gets underway. Functioning as a nonprofit corporation, the commission plans to employ as director a physician experienced in hospital administration, who, with the aid of a limited clerical staff, will manage its affairs.

The functions of the commission will be to formulate standards relating to hospital accreditation, to establish the type and scope of inspections to be made under this program, to assign responsibility for hospital inspections to the several participating organizations, and to award certifi-

cates of accreditation to qualifying hospitals. At the present time, there are 3,200 hospitals approved by the American College of Surgeons.

Inspections for purposes of hospital accreditation will be made and reported in a uniform manner by staff representatives of the participating organizations, with the reports to be evaluated and acted on by the commission itself. Inspections will relate primarily to the professional and administrative aspects of the hospital. They will not be concerned directly with the hospital's teaching program.

The creation of the national Joint Commission for the Accreditation of Hospitals marks the culmination of earnest effort to resolve seemingly irreconcilable differences and becomes a noteworthy achievement looking to continued improvement of hospital and medical care for the patient. Comments the Journal of the American Medical Association editorially:

"Agreement on a cooperative basis for carrying out this important program marks a milestone in the history of the relations between these four organizations. It gives confirmation to the belief that though the views of the several groups may at times appear to be in conflict, differences of opinion can be settled if the ultimate objective, that of better patient care, is kept in mind.

"This cooperative effort refutes those who claim that problems confronting the profession and hospitals today can be resolved only by the intervention of an outside agency. In the same spirit of mutual help, the profession and hospitals can and will move forward in a concerted effort to provide an even better product of physician-hospital care for the final arbiter of its worth, the public."[1]

1. Joint Commission for the Accreditation of Hospitals, J. A. M. A. 147:761-762 (Oct. 20) 1951.

California Takes Heed

Meeting late in August, the state bar of California took cognizance of the increased awakening of lawyers in many sections of the country to the threats of "socialization of the practice of law" and proposed a counteroffensive. Leaders of this organization said that pressures have been increasing for a number of years in behalf of programs giving government enlarged powers over various phases of legal practice. They observed that one of the avenues of attempted socialization is establishment of legal reference services under state or local government jurisdiction.

The California Bar took immediate steps to establish a lawyer reference service in each community. Its members were of the opinion that this measure would solve the problem of many potential clients who do not know how to find a reputable lawyer — within the existing professional and economic framework.

The persistent drive for socialized medicine, not only in California but nationally, has led the legal profession to look to its own vulnerability, bar members frankly admitted. This trend is apparent in the many requests from bar associations for medicine's "Simplified Blueprint of Campaign," received by Whitaker & Baxter, the American Medical Association's public relations firm. This increasing interest should facilitate a closer working relationship between medical societies and bar associations against the common threat of socialization.

School of Cytology

The Cancer Cytology Center of the Dade County Cancer Institute, an affiliate of the Medical Research Foundation of Dade County in Miami, has announced its first one-week seminar for physicians to be held at the Institute from January 14 to 19 inclusive. The lecture courses are scheduled from 9 a.m. to 5 p.m. daily during this period.

Instruction will be under the supervision of Dr. J. Ernest Ayre, Director of the Institute and its research staff. More than twenty outstanding local and visiting physicians and scientists will compose the faculty.

This first School of Cytology in Florida anticipates enrolment from local, State and regional areas as well as from the Caribbean.

The general course of instruction in cancer diagnosis and cytology will include lectures, demonstrations and symposiums covering the various branches of medicine as related to cancer, including clinical, cytological, surgical and histopathological fields.

Interested physicians should direct their inquiries regarding qualifications, registration, fees and other details to the Director of the Dade County Cancer Institute at 1155 North West 14th Street, Miami.

Applications for registration, limited to 35 physicians, will be accepted through January 12.

Student American Medical Association Journal

In January, the first issue of a 72 page Journal of the Student American Medical Association will be out. Published monthly, except in July, August and September when the schools are closed, this new journal will have a circulation of more than 33,000. Some 26,000 medical students and approximately 7,000 interns will receive it.

This publication will enable the Student American Medical Association to "provide the young doctor with a broader realization of the socio-economic aspects of medicine" and also to "demonstrate to tomorrow's doctors their duties and responsibilities not only as physicians but as citizens in their respective communities. It will also show the young doctor why the nation's medical schools need his enthusiastic support to continually improve medical education."

Regional Meeting of American College of Physicians

The Southeastern Regional Meeting of the American College of Physicians was held at the George Washington Hotel in Jacksonville on November 2 and 3, 1951. Of the 115 registrants, there were 10 from Alabama, 76 from Florida, 14 from Georgia and 12 from South Carolina, the states comprising the region, and 1 from Cuba, which is also included in the area; in addition, there was 1 from Tennessee and 1 from Pennsylvania.

The excellent program was well received, the papers comparing favorably with those presented at the national meetings. The five Florida physicians participating in the diversified program were Drs. E. Sterling Nichol, Miami, Bernard J. McCloskey, Jacksonville, and, by invitation, John S. Graettinger, Pensacola, Daniel R. Usdin and Donald P. White, Jr., Jacksonville.

At the banquet on Friday night, Dr. Edward L. Bortz of Philadelphia, a Regent of the College, presented an address on "The Challenge of Growth." He also lectured at the morning session on "Nutritional Deficiencies and Premature Ageing."

Entertainment for the ladies was provided by the wives of the local members of the College. On Saturday afternoon, Mr. Robert Kloeppel, Sr., was host to all who wished to remain over for a yacht trip down the St. Johns River.

Dr. William C. Blake of Tampa, Governor for Florida, was chairman of the meeting. Presiding at the afternoon session on Friday was Dr. E. Dice Lineberry of Birmingham, Governor for Alabama, and at the Saturday morning session, Dr. Robert Wilson, Jr., Governor for South Carolina. Toastmaster at the banquet was Dr. Carter Smith of Atlanta, Governor for Georgia. Dr. Jose J. Centurion of Havana is Governor for Cuba. The Regional Meeting in the fall of 1952 will be held either in Havana or Atlanta.

New Doctor Draft Interpretations

The National Advisory Committee to Selective Service has released the following information relative to the Doctor-Draft act:

"1. When delay in active duty is requested for a Naval reserve medical officer, the request must be signed by the state chairman and must clearly state that the officer is essential in his present capacity.

"2. World War II deferment of medical students, resulting in their being placed in Doctor-Draft Priorities I or II, must have taken place in part at least within the period December 7, 1941 to March 31, 1947.

"3. The Doctor-Draft act applies only to World War II deferments granted by the Selective Service System, and not to active duty deferments granted to reserve officers by the military services. Therefore, a registrant who received deferment under the latter conditions is not by reason of this to be placed in Priorities I or II."

Medical Stockpile Program Lagging

Apparently the nationwide medical stockpile program is lagging, according to information from the A. M. A. Washington office.* This is mainly because the majority of the states have not sent plans to Washington for approval. In the early part of the year, the delay was on the federal level due to lack of funds, but now the Federal Civil Defense Administration has the money to be used on a 50-50 matching share of local stockpiles.

The following information is quoted from the Capitol Clinic and depicts the status of the medical stockpile program at the end of November.

"Actually, only 12 state plans have been processed to the point where orders have been filled with the Armed Services Medical Procurement

Agency, which will do the pooled purchasing. Some of these states should be receiving first shipments during December. Fifteen other states, for which CDA several months ago allocated money — all containing one or more likely target areas — have yet to submit acceptable plans. Available for distribution to the states is the bulk of a $20 million appropriation.

"Under the master plan, these U.S.-state stockpiles are expected to take care of casualties during the first four hours after an attack. By then, it is expected that suppplies will be received from regional stockpiles, set up and maintained entirely by federal funds. These U.S. medical depots will be located, wherever possible, within four hours trucking time of critical target areas.

"Because funds for the all-U.S. regional stockpiles were voted late in the session, they probably will not be set up for several months. Meanwhile, emphasis is on hurrying state and community programs which would be the first line of medical defense in case of an attack. There are some production difficulties, principally with standard burn pads, certain textiles, duck fabrics and instruments, but no critical delays are expected, provided the states draw up their programs in time."

*Capitol Clinic Vol. 2, No. 48, Nov. 27, 1951.

New Plaque for Your Office

After several years hearing and investigating patient complaints against physicians, grievance committees throughout the nation have announced similar findings. Most complaints arise due to misunderstanding, particularly in regard to fees, and as to what services have been rendered for those fees. They have also found that the majority of grievances are amicably settled through explanation by the doctor to his patient. It is evident, therefore, that a frank discussion of fees and services in the beginning would tend to forestall misunderstandings and aggrieved patients.

Patients have an understandable reluctance to discuss fees with their doctors. This can be counteracted largely by each doctor helping his patients to realize that he wants to talk to them, and to arrive at a friendly mutual understanding. They should be encouraged to seek answers for any questions they may have.

As an aid to the busy doctor who can ill afford to take the time which may be necessary tactfully to open a discussion on fees and services, a simple device for doctors' offices is available from the American Medical Association. This is an attractive office plaque which reads:

To All My Patients

I invite you to discuss frankly with me any questions regarding by services or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient.

This plaque is described and illustrated on page 512 of this Journal. It should be given a prominent place on every physician's waiting room wall, receptionist's desk or other place where patients cannot possibly fail to see it. The price is $1.00.

Your "Briefs" of December 5 announced this invaluable public relations aid. With this "Briefs" each member received an order envelope so that to get your plaque, if you have not already done so, simply place $1.00 in this envelope, write your name and address on the inside of the flap and mail. If you have mislaid your order envelope write the Florida Medical Association, Box 1018, Jacksonville, for another, or turn to page 512 and see how you may order direct from the A. M. A.

Graduate Medical Education

A meeting of the division chairmen of the Faculty of the Department of Medicine of the Graduate School of the University of Florida was held recently in Jacksonville. It was agreed that the Faculty would present a full day's course in any part of the state where its services were desired in an attempt to bring graduate medicine as close to the physicians as possible.

* * *

Plans are under way for the Twentieth Annual Graduate Short Course, which will be held at the George Washington Hotel in Jacksonville, June 23-28, 1952. Immediately preceding that meeting, on Thursday, Friday and Saturday, June 19-21, there will be lectures on Diagnosis. The plans are to present the subject from the clinical standpoint, the roentgenologic standpoint and the laboratory standpoint. On Saturday these three approaches to diagnosis will be correlated.

STATE NEWS ITEMS

Dr. Walter C. Jones of Miami has been named president-elect of the Southern Medical Association at its annual convention in Dallas, Texas, Nov. 5-8, 1951. Dr. Jones, who is a past president of F. M. A., will take office as president at the 1952 meeting of the Southern Medical Association in Miami.

Fifty members of the Association registered at the meeting of the Southern Medical Association held in Dallas, Texas, Nov. 5-8, 1951. They are: Drs. Richard C. Forman and James F. Lyons, Coral Gables; William D. Cawthon, DeFuniak Springs; M. Austin Lovejoy, Ft. Lauderdale; William C. Thomas, Sr., Gainesville; Sullivan G. Bedell, A. Judson Graves, James G. Lyerly, John M. McDonald, William A. Van Nortwick and Donald P. White, Jr., Jacksonville; Jere W. Annis and John W. Vaughn, Lakeland; A. Scott Turk, Lake Worth; Albert E. McQuagge, Marianna; Theodore J. Kaminski, Melbourne; Julius Alexander, Ralph F. Allen, Dewitt C. Daughtry, Herbert Eichert, M. Jay Flipse, James J. Griffitts, Walter C .Jones, Nathaniel M. Levin, R. Sam Mosley, E. Sterling Nichol, J. Randolph Perdue, Maurice Rich, George F. Schmitt, Donald W. Smith and Richard F. Stover, Miami; Abraham R. Hollender, Jean J. Perdue and Virgil H. Pieck, Miami Beach; Sanford C. Colley, Mt. Dora; Chas. J. Collins, James G. Economon, Elwyn Evans, James B. Glanton, William H. Kelley, Fred Mathers and John P. Michaels, Orlando; Arthur J. Butt, Charles W. Duval, S. Grant Holmes and Jesse N. McLane, Pensacola; Abraham J. Gorday, St. Petersburg; Chadbourne A. Andrews, Joshua C. Dickinson and Oren A. Ellingson, Tampa.

Dr. Walter C. Payne of Pensacola has been reappointed to the State Advisory Hospital Council by Governor Warren.

Dr. Frank G. Slaughter, Jacksonville, addressed a recent luncheon meeting of the Temple Sisterhood in the Temple Auditorium in Jacksonville. His subject was "The Art of Writing."

Dr. Nelson A. Murray of Jacksonville has returned to his practice after completing a study course at the Mayo Clinic in Rochester.

Dr. Thomas H. Bates of Lake City, president of the Atlantic Coast Line Railway Surgeons Association, has announced the annual meeting of the Association to be held in Charleston, S. C., Jan. 24-25, 1952. Dr. Joseph S. Stewart of Miami, F. M. A. past president, will be the guest speaker at the banquet. He will be accompanied on the program by Dr. James G. Lyerly of Jacksonville.

Dr. Stewart Thompson and Ernest Gibson attended the Conference of Editors and Business Managers of State Medical Journals, November 12 and 13, in Chicago.

Drs. Bricey M. Rhodes and James H. Pound of Tallahassee have recently returned to their practices following a two weeks visit to The Mayo Foundation in Rochester, Minn.

Dr. James R. Sory of West Palm Beach was elected chairman of the Palm Beach County Unit, American Cancer Society, at the group's annual meeting, November 16.

Dr. Egbert V. Anderson of Pensacola was elected president of the Florida State Pediatric Association at the annual meeting in Orlando, November 10 and 11. Other officers for the new year include Drs. Charlotte C. Maguire, Orlando, president-elect; J. K. David, Jr., Jacksonville, secretary-treasurer, and C. Jennings Derrick, West Palm Beach, and Fred Gachet, Lakeland, members of the executive committee.

Dr. Donald W. Smith, Miami, was named vice president of the American Association of Blood Banks at the annual meeting in Minneapolis recently.

Dr. Sidney Grau of St. Petersburg spoke before the recent annual convention of the Florida State Nurses Association in St. Petersburg. His subject was "The Care of the Cardiac Patient."

Dr. Nathan Weil, Jr., of Jacksonville spoke on "Cancer, Its Danger Signals and Cure" before the November meeting of the Jacksonville Panhellenic Association.

Dr. Robert A. Broome, Jr., Orlando, discussed heart disease research at a luncheon meeting of the Civitan Club on October 31.

Dr. George H. Garmany of Tallahassee has returned to his practice from a month's course in Encephalography in Boston.

Dr. Burns A. Dobbins of Ft. Lauderdale was guest speaker on November 8 at the luncheon meeting of the Zonta Club of Ft. Lauderdale. Dr. Dobbins spoke on "Mental Health."

Dr. Charlotte C. Maguire, Orlando, was a recent guest speaker at the monthly meeting of the Orlando Business and Professional Women's Club. Her subject was "Medicine and its Growth."

Dr. Joshua M. Price of Live Oak was recently saluted by the Suwannee Democrat for his nearly fifty years of service to his fellow men. Dr. Price began his practice of medicine in Live Oak in 1904, following his graduation from Tulane University. Currently chief of staff at the Suwannee County Hospital, he is still active in the practice of his profession.

Drs. Sullivan G. Bedell, Marlin C. Moore and Gary E. Turner, Jacksonville, participated in an institute on "Living in the Adult World" held by the Northeast Medical Health Association in November.

Members of the Florida Medical Association registered at the Clinical Congress of the American College of Surgeons in San Francisco, Nov. 5-9, 1951, were Drs. Peter A. Drohomer, Daytona Beach; Horace M. Anderson, Frederick H. Bowen, Edward Canipelli, E. Frank McCall and Wm. S. Manning, Jacksonville; John N. Sims, Sr., Live Oak; Francis N. Cooke, Miami; Frank E. Tugwell, Pensacola; Walter Rautenstrauch, Jr., St. Petersburg; Louise A. Box, Robert H. Hutchinson, and Charles F. James, Jr., Tallahassee; Wade C. Myers, Jr., Tampa; Raymond S. Roy and Vale D. Stone, West Palm Beach; and Ruth S. Jewett, Winter Park.

Drs. A. Sherrod Morrow and Joseph J. Lowenthal of Jacksonville have returned to their practices after attending a course in postgraduate medicine at the Pratt Diagnostic Clinic.

The University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held in Miami Beach, Jan. 14-19, 1952, for the sixth consecutive year. The Sans Souci Hotel is headquarters. The lectures on Ophthalmology will be presented on January 14, 15 and 16, and those on Otolaryngology on January 17, 18 and 19.

The Florida Society of Ophthalmology and Otolaryngology will hold its midwinter convention at the Sans Souci Hotel in Miami Beach on Jan. 16, 1952. This meeting is held annually in conjunction with the University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology.

The Southern Section of the American Laryngological, Rhinological and Otological Society will hold a one day meeting at the Academy of Medicine in Atlanta, Ga., on Monday, Jan. 14, 1952. Six distinguished speakers will present timely subjects. All members of the medical profession are cordially invited to attend.

The Pan-American Congress of Oto-Rhino-Laryngology and Broncho-Esophagology will convene in Havana, Cuba, the week of Jan. 21, 1952. This meeting was planned to follow the University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology, which will be held in Miami Beach the preceding week.

Dr. Gordon H. Ira of Jacksonville has returned to his practice after taking a course in New York under the auspices of the American College of Chest Physicians.

The Commissioner of Internal Revenue of the Treasury Department has ruled that contributions, payment of which were made to the American Medical Education Foundation during the year 1951, are deductible by the donors in computing their taxable net income in the manner and to the extent provided by Section 23 (o) and (q) of the Internal Revenue Code. The Commissioner's ruling was based on his finding that for the year 1951, it appeared that the Foundation was organized and operated exclusively for educational purposes. This information has been supplied the Journal by Dr. Donald G. Anderson, secretary-treasurer, the American Medical Education Foundation.

Dr. David R. Murphey, Jr., President; Dr. Eugene B. Maxwell, Chairman of the Committee on Public Relations; Dr. Stewart Thompson, Managing Director; and Tom Jarvis, Assistant Supervisor of the Bureau of Public Relations, held a conference in Tampa on Sunday, November 18, dealing with a proposed F. M. A. exhibit to be presented initially at the Florida State Fair in Tampa during February, 1952.

Dr. Theodore Norley of West Palm Beach talked and showed a film on "Congenital Dysplasia of the Hip Joint in Infants and Children" before fellow members of the West Palm Beach Rotary Club at a recent weekly luncheon.

Dr. Elwyn Evans of Orlando, President of the Florida Heart Association, and Dr. Jere W. Annis, representing the Florida Medical Association, participated in the panel discussion at an institute for employers held November 14 in Tampa by the Florida Heart Association. The institute was held to study the employment of workers with heart impairments.

Dr. John P. Michaels of Orlando has returned from a meeting of the Gynecological Visiting Society of Great Britain and Ireland and the American Gynocological Club in New Orleans.

Dr. Warren W. Quillian, Coral Gables, was installed as president of the American Academy of Pediatrics at its annual meeting in Toronto, Oct. 20-25, 1951.

Association members registered at the meeting of the American Academy of Pediatrics in Toronto, October 20-25, include: Drs. Gunnard J. Antell and Warren W. Quillian, Coral Gables; Robert R. Harriss, Hollywood; Cornelia M. Carithers, Hugh A. Carithers and Frances E. M. Read, Jacksonville; James R. Boulware, Jr., and Fred S. Gachet, Lakeland; Elias Freidus and Meyer B. Marks, Miami Beach; George W. Griffin and John D. McKey, Orlando; Henry G. Morton, Sarasota; George S. Palmer, Tallahassee; and Rita C. Marotti, Winter Haven.

Dr. Gary E. Turner, Jacksonville, participated in a panel discussion on "Freedom to Accept Self" at the November meeting of the American Association of University Women.

Dr. Marlin C. Moore of Jacksonville attended several clinics in the eastern states during October.

Dr. Chadbourne A. Andrews of Tampa has been reappointed a member of the Council of the Southern Medical Association representing Florida.

Dr. Walter W. Sackett, Jr., Miami, was elected vice-chairman of the section on General Practice of the Southern Medical Association at its Dallas meeting in November.

Dr. Donald W. Smith of Miami was elected secretary of the section on Surgery of the Southern Medical Association at its annual meeting in November.

Dr. Claude G. Mentzer of Miami was elected vice-chairman of the section on Proctology at the annual meeting of the Southern Medical Association.

Dr. Jean J. Perdue of Miami Beach was elected chairman of the Women Physicians of the Southern Medical Association at the meeting in Dallas.

Dr. Knox E. Miller of Jacksonville, assistant state health officer of the Florida State Board of Health, attended the two day Medical Civil Defense Conference held in Chicago in early November. Dr. Miller represented Dr. James L. Borland, chairman, F. M. A. Committee on Emergency Medical Service, and Dr. Wilson T. Sowder, state health officer.

Dr. Robert V. Artola of West Palm Beach was recently elected president of the Inter-American Club, an organization in the Palm Beaches for the promotion of international relations with Latin America.

Miami has been selected as host city for the 1954 A. M. A. Clinical Session, November 30-December 3.

In January, the Association's 1952 Florida Medical Directory is scheduled for mailing. It will be the fifteenth edition. One copy will be mailed to each member of the Association without charge. Members desiring additional copies or others who wish the publication should forward a remittance of $2.00 to Box 1018, Jacksonville.

Medical Officers Returned

Dr. Francis N. Cooke, who entered military service on Nov. 24, 1948, was released from active duty on Oct. 1, 1951 with the rank of Lieutenant Colonel. His address is Box 2318, Miami, Florida.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Joseph W. Taylor, Jr., of Tampa announce the birth of a daughter, Janet Stuart.

Dr. and Mrs. James C. Lanier of Jacksonville announce the birth of a son, James C. Lanier, IV, on Nov. 1, 1951.

Deaths — Members

Dickerson, Lucien B., Clearwater.....Nov. 3, 1951
Mount, Louis B., St. Petersburg.....Dec. 10, 1951

Deaths — Other Doctors

Freney, John D., Waterbury, Conn.....Aug. 11, 1951
Taylor, Quintard, White Sulphur Springs, W. Va. Aug. 30, 1951

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Barrow, George W., Winter Garden
Bleakney, Rex M., Orlando
Hicks, Lawrence, (Col.) Pensacola
Tomson, Nathaniel C., St. Petersburg
Townes, Andrew W., Jr., Orlando

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

FOR SALE: Eye equipment. Slit lamp, lensometer, contact lens set, other minor instruments, some office equipment and ear, nose and throat items. Write William H. Turnley, M.D., 1206 E. Ocklawaha Ave., Ocala, Fla.

FOR SALE: New modern hospital furniture and fixtures. Write 69-59, P. O. Box 1018, Jacksonville, Fla.

WANTED: Association with group practice or with busy general practitioner in central or southern Florida. I have excellent background and training. Personal interview preferred. Write 69-60, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: X-ray equipment and practice. North Florida city. Retiring for health reasons. Excellent location serving large territory. Nearest competition fifty miles. Will sacrifice. Write P. O. Box 667, Lake City, Fla.

COMPONENT SOCIETY NOTES

Alachua

At the regular November meeting of the Alachua County Medical Society, Dr. Charles Pinkoson of Gainesville led a discussion on the use of ACTH and cortisone in treating eye conditions.

Duval

The Duval County Medical Society has accepted an invitation from the medical staff of the local Naval Air Station to be their guests for the January meeting at the Naval Hospital.

Hillsborough

The theme of the joint meeting of the Hillsborough County Medical Association and the Pinellas County Medical Society on Nov. 6, 1951, in Tampa, was medical public relations. Heading the program were Drs. David R. Murphey, Jr., F. M. A. president, and Eugene B. Maxwell, chairman of the F. M. A. committee on public relations, both members of the Hillsborough County Medical Association. The program was in charge of Dr. Wesley W. Wilson, program chairman. Included on the program from the Pinellas Society were Drs. John P. Rowell, president, and Francis H. Langley, both of St. Petersburg. Also in attendance was Tom R. Jarvis, assistant supervisor, F. M. A. Bureau of Public Relations.

Lake

The Lake County Medical Society is sponsoring a series of thirteen programs over radio station WLBE, Leesburg. Each program presents organ selections from master composers of the past each of whom had a particular health problem. Commentary accompanying the music indicates how these health problems might have been relieved by modern medical knowledge.

Leon-Gadsden-Liberty-Wakulla-Jefferson

The Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society held its final quarterly meeting for 1951 on October 18 at the Sawano Country Club in Quincy. The scientific program was headed by an address on "Vasodilator Drugs" by Dr. Arthur P. Richardson, Chairman, Department of Pharmacology, Emory University School of Medicine. Following Dr. Richardson's talk, a film on "Gastrointestinal Carcinoma" was presented.

Marion

Guest speaker at the regular monthly meeting of the Marion County Medical Society on Nov. 27, 1951, was Dr. Lorenzo L. Parks of Jacksonville, Director of the Bureau of Preventable Diseases of the Florida State Board of Health.

During the 1951 football season, the society performed a valuable public service by having one of its members attend each of the games of the local high school. This made certain that there was always a doctor available to render first aid and such other medical help as required.

Pinellas

Beginning in January, the Pinellas County Medical Society in conjunction with the St. Petersburg Times, will launch a novel program designed to present public information on medical and health problems. Members of the society will participate in a series of weekly forums wherein they will lecture on and answer previously submitted questions on such topics as the common cold, heart conditions, mental health, and many others. Present plan is to present one program each week during the months of January, February and March. Lectures are to be given in a down town church auditorium. The public has been given an opportunity to help select the topics for discussion through the medium of a medical form blank published in previous issues of The Times.

OBITUARIES

Joe Ivey Turberville

Dr. Joe Ivey Turberville of Century met death in an automobile accident at Grove Hill, Ala., on Oct. 20, 1951. He was 48 years of age. Interment was in Pensacola.

Although he had lived most of his life in Century, Dr. Turberville was born in Peterman, Ala. He attended the Escambia County schools, the Gulf Coast Military Academy and the University of Alabama. He received his medical training at Vanderbilt University and at the Medical College of Virginia, where he was awarded the degree of Doctor of Medicine in 1929. He then served an internship at the Tampa Municipal Hospital in Tampa.

Upon the completion of his intern training, Dr. Turberville became associated with his father, the late Dr. John Samuel Turberville, in operating the Turberville Hospital in Century. Later, his brother, Dr. John Killiebrew Turberville joined them, and after the father was killed in a similar tragedy in 1945, the two brothers continued to operate the hospital.

Locally, Dr. Turberville was a member of the Century Masonic Lodge 243 and a Shriner. He was a member of the Methodist Church. His medical fraternity was Phi Chi.

A past president of the Escambia County Medical Society, Dr. Turberville was a member of the Florida Medical Association and the American Medical Association. He was also a fellow of the American College of Surgeons.

He is survived by his widow, Mrs. Ellen Burns Turberville; four daughters, Virginia, Dorothy, Elizabeth and Jo Ellen; his mother, Mrs. Julia Turberville, all of Century; four sisters, Miss Kathleen Turberville of Tampa, Mrs. Fred Johnson of Century, Mrs. John W. Holmes of Furman, Ala., and Mrs. C. S. Peters of Mobile, Ala.; and two brothers, Dr. John K. Turberville and William G. Turberville of Century.

John Killiebrew Turberville

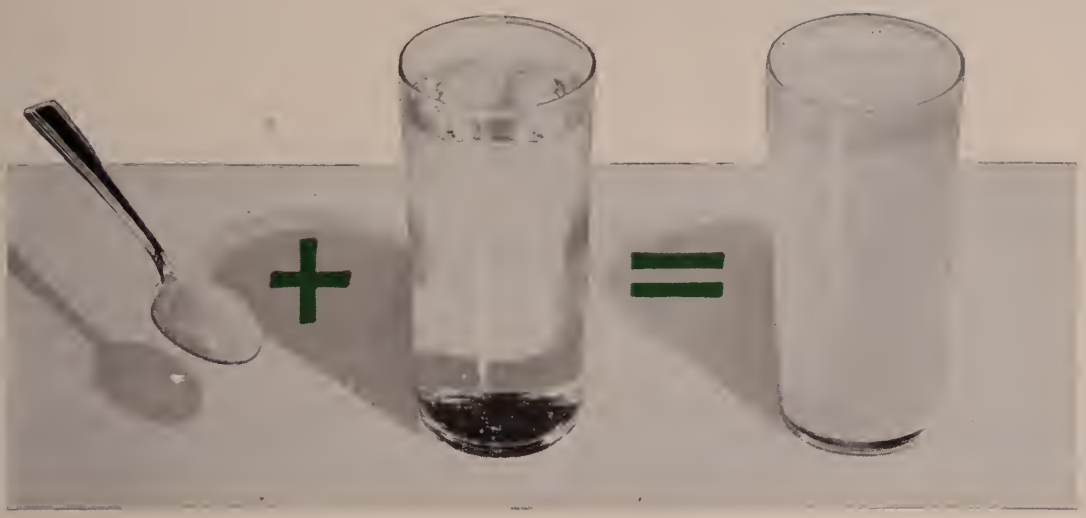
Dr. John Killiebrew Turberville of Century died suddenly of a heart attack while at his desk on Nov. 1, 1951. He was 46 years of age. Funeral services were held in Century with interment in Pensacola.

Born at Snow Hill, Ala., Dr. Turberville moved to Century shortly afterward. He attended the Escambia County public schools and received his premedical training at Howard College and the University of Alabama. The Tulane University of Louisiana School of Medicine awarded him the degree of Doctor of Medicine in 1935. After interning at Touro Infirmary in New Orleans, he entered the practice of medicine at the Turberville Hospital in Century with his father, the late Dr. John Samuel Turberville, and his brother, the late Dr. Joe Ivey Turberville, the latter preceding him in death by only twelve days. His death left the hospital and Century without a physician.

(*Continued on page 506*)

Normohydration

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

(Continued from page 504)

Dr. Turberville was a member of the Escambia County Medical Society, the Florida Medical Association, and the American Medical Association, and a fellow of the American College of Surgeons. He was a Mason, a Shriner and a member of the Lions Club.

Surviving are the widow, Mrs. Veronica Turberville; three sons, Jack, John Samuel, and John Killiebrew, Jr.; one daughter, Veronica; his mother, Mrs. Julia Turberville; one brother, William G. Turberville, all of Century; and four sisters, Miss Kathleen Turberville of Tampa, Mrs. Fred Johnson of Century, Mrs. John W. Holmes of Furman, Ala., and Mrs. C. S. Peters of Mobile, Ala.

Lucien Brown Dickerson

Dr. Lucien Brown Dickerson of Clearwater died on Nov. 3, 1951, at his fishing camp in Homosassa Springs. He was 75 years of age.

The son of Newton and Anna Watson Dickerson, Dr. Dickerson was born in Nicholasville, Ky., on June 5, 1876. After completing his high school education there, he entered Center College and was graduated in 1897. He received the degree of Doctor of Medicine from the Univeristy of Louisville School of Medicine in 1903.

Dean of Clearwater physicians, this pioneer surgeon entered the private practice of medicine in Clearwater in 1904. By bicycle he covered the territory from Dunedin to Largo until he acquired an automobile in 1907. In 1916 he delivered the first baby born at Morton Plant Hospital. He performed the first major operation there, on Morton F. Plant's son, and was the first chief of staff of the hospital. For many years he served as house doctor for the Belleview Biltmore Hotel



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at Belleair and was also county health doctor. Dr. Dickerson played a leading role in the early development of the section and served as physician to many of Clearwater's pioneer families. He was a charter member of the Clearwater Country Club and the Clearwater Yacht Club, and was a past commander of the Turner-Brandon Post No. 7, American Legion of Clearwater.

In August 1917 Dr. Dickerson enlisted in World War I, serving two years, part of which time was spent in France with the Combat Field Hospital Division. This motor unit had the first field hospital mobile unit. After the war, he returned to Clearwater, where he continued to practice until 1945, when he retired following his wife's death and because of ill health. Thereafter he spent much of his time at his Homosassa residence.

An ardent sportsman, Dr. Dickerson played professional baseball in the Blue Grass League for three years prior to studying medicine. At one time he was champion of the Florida Medical Association golf team and of the Clearwater Country Club.

Dr. Dickerson helped to organize the Pinellas County Medical Society and was its first president. For thirty-two years he was an active member of the Florida Medical Association and for five years an honorary member. He also held membership in the American Medical Association.

Survivors include two brothers, Woodson Dickerson of Orlando and Julian Dickerson of Nicholasville, Ky.; two sisters, Mrs. Scott Mathews of Nicholasville and Mrs. J. H. Marriott of New Orleans; three nieces, Mrs. Howard C. Van Hyning, Mrs. George Dalby and Mrs. Robert B. Swearingen, all of Clearwater, and other nieces in Kentucky.

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting January 21, February 4, February 18. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 3, June 2. Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 17, June 16. Surgery of Colon & Rectum, One Week, starting March 3, April 7. Gallbladder Surgery, Ten Hours, starting April 21. Basic Principles in General Surgery, Two Weeks, starting March 31. Breast & Thyroid Surgery, One Week, starting June 23. Esophageal Surgery, One Week, starting June 23. Thoracic Surgery, One Week, starting June 2. Fractures & Traumatic Surgery, Two Weeks, starting February 4.

GYNECOLOGY—Intensive Course, Two Weeks, starting February 18, March 17. Vaginal Approach to Pelvic Surgery, One Week, starting March 3, March 31.

OBSTETRICS—Intensive Course, Two Weeks, starting March 3, March 31.

MEDICINE—Intensive General Course, Two Weeks, starting May 5. Electrocardiography & Heart Disease, Two Weeks, starting March 17. Gastroenterology, Two Weeks, starting May 19. Hematology, One Week, starting June 16.

UROLOGY—Intensive Course, Two Weeks, starting April 28. Ten Day Practical Course in Cystoscopy starting January 21, February 18 and every two weeks.

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MRS. ALPHONSUS M. McCARTHY, Hospitality *Daytona Beach*

Assignment in April

In every organization there comes a season of flowering in the field of effort which had to be ploughed and worked by many who went before, without whom there could be no blossoming if they had not planted and nurtured the ideas.

Because of those who believed in the organization, we have growing unity throughout the state.

Because of those who believed in education, we have been able to institute "work-shop" sessions at the district meetings, and will see the introduction of an Auxiliary Handbook this year.

Because of those who sensed the need of good public relations we have an increasing number of alert, informed doctors' wives taking part in virtually every civic effort.

And, last but not least, because we have steadfastly served the Doctor we have earned the confidence and respect of the Medical Association to the extent that we have been asked to provide the entertainment for the Association following the program at the annual dinner Tuesday night, April 29, 1952. This means providing a program of entertainment and fun which will appeal to all but which will cost nothing inasmuch as neither the Florida Medical Association nor the Auxiliary has funds for this purpose.

However, since the tastes throughout the state vary, as well as the talent which we must provide from within our own groups, I am asking each county auxiliary to cooperate with me in finding the best talent the county society or the auxiliary has to offer and submit the name to me which is selected by the majority approval of that county.

Dr. David Murphey has appointed a chairman from the Association to work with us on this but before I can work with him I must have suggested talent material.

The need for this type of congenial fun has long been felt in order to create a closer feeling throughout the state among the members who attend the meeting.

I trust and hope that each county auxiliary will welcome this idea as enthusiastically as I did in assuring Dr. Murphey that it would be a pleasure since it is one of the first objectives of our organization to assist in the entertainment at conventions, and to promote mutual understanding among physicians' families.

Mrs. C. Robert DeArmas, President.

BOOKS RECEIVED

The Scottish Chemist's Index of Modern Remedies 1951. By Alexander Murray, M.P.S., Proprietor, and Scott Murray, Editor. Pp. 116. Price, $2.00. Glasgow, Scotland, The Scottish Chemist, 1951.

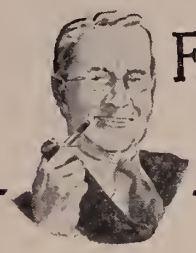
Designed to prove a valuable reference to all who are engaged in medicine and pharmacy, this first North American Edition of the Index of Modern Remedies places before these professions a concise listing of ethical products available in the United States, Canada and Great Britain. Products listed are not meant to take the form of a complete dictionary, but rather to serve as a guide to alternate prescribing in any one particular field. While many other products are available, their active constituents, generally, are embodied in those detailed. The address for the United States and Canada is Box No. 275, Terminal "A," Toronto, Ontario, Canada.

The Rockefeller Foundation Directory of Fellowship Awards for the Years 1917-1950. With an Introduction by Chester I. Barnard, President of the Foundation. 49 West 49th Street, New York, N. Y. Pp. 286.

The granting of fellowships has always been one of the primary interests of The Rockefeller Foundation. It has for many years operated through five divisions: International Health Division; Medical Sciences; Natural Sciences; Social Sciences; and Humanities. Some idea of the extent of the Foundation's fellowship program and of the positions now held by the fellows themselves can be gained from this directory, listing the men and women who at some time in the past thirty-five years held Foundation fellowships.

In the Medical Sciences, as stated in the introduction, there was from the start an insistent emphasis on the promotion of research. Also present has been the idea of multiplying centers from which medical skill, acquired by physicians through their fellowship training under famous medical specialists, could radiate into new areas. Former fellows in medicine in many instances have qualified for leading roles in the creation of strong outposts in the battle against disease.

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by Joe Marsh

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From where I sit, these boys—and volunteer firemen everywhere—stand for something mighty important to this nation. Most things seem to work out better when they're done *voluntarily.* Whether it's a ballplayer or a beverage you're choosing, whether it's the way to run a newspaper or how to practice a profession, it's the individual freedom of choice that has made America great.

Joe Marsh

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John H. Lamb, M.D., Oklahoma City, Okla.
Dermatology

J. Arnold Bargen, M.D., Rochester, Minn.
Gastroenterology

Ralph A. Reis, M.D., Chicago, Ill.
Gynecology

Charles A. Doan, M. D., Columbus, Ohio
Medicine

John P. Merrill, M. D., Boston, Mass.
Medicine

William Parson, M.D., Charlottesville, Va.
Medicine

Jacob E. Finesinger, M.D., Baltimore, Md.
Neuropsychiatry

Leroy A. Calkins, M.D., Kansas City, Kan.
Obstetrics

John H. Dunnington, M.D., New York, N. Y.
Ophthalmology

Edward L. Compere, M.D., Chicago, Ill.
Orthopedic Surgery

Hayes Martin, M.D., New York, N. Y.
Otolaryngology

Oscar B. Hunter, Sr., M.D., Washington, D. C.
Pathology

Margaret M. Nicholson, M.D., Washington, D. C.
Pediatrics

Paul C. Swenson, M.D., Philadelphia, Pa.
Radiology

Richard B. Cattell, M.D., Boston, Mass.
Surgery

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Statistics for Medical Students and Investigators in the Clinical and Biological Sciences. By Frederick J. Moore, M.D., Frank B. Cramer, B.A., and Robert G. Knowles, M.S. Pp. 113; figures 11; tables 16. Price, $3.25. Philadelphia, The Blakiston Company, 1951.

This text and reference, which is an introduction to study of the behavior of quantities, is written primarily for medical students, research workers in medicine and the biological sciences, and practitioners who wish to understand and interpret more readily the commonly used statistical forms found in scientific and medical research reports. It helps them understand and evaluate, not merely accept, statistical findings. Not only is it extremely valuable in estimating the value of research reports, but it is also a helpful aid in preparing such reports. It presents in ordinary language the essential mathematical reasoning underlying common statistical procedures. Examples are chosen entirely from the field of medicine and presuppose only the mathematics which the physician or student would acquire naturally in premedical or medical training. Each chapter contains tables, illustrative figures, an introduction and a summary.

Biological Antagonism, the Theory of Biological Relativity. By Gustav J. Martin, Sc.D. Pp. 516, figs. 64, tables 44. Price, $8.50. Philadelphia, The Blakiston Company, 1951.

Released for publication in November, this book offers a thorough, complete, yet concise, presentation of the theory of biologic relativity — that "general law" which underlies all biologic activity and is fundamental to the resolution of all problems in biology.

The author reviews biologic antagonism as reflected in natural and synthetic displacing agents, covers antagonism as seen in the fields of amino acids, purines, pyrimidines, vitamins, hormones, minerals, and as it forms the basis of immunology, pharmacology, and chemotherapy. Finally, he presents the concept of biologic relativity based upon extensive study of these biologic antagonisms.

Research workers in immunology, pharmacology, chemotherapy, medicine, and the entire field of biology will find the 1,900 references throughout the book extremely helpful. They represent a comprehensive survey of all the literature in the field.

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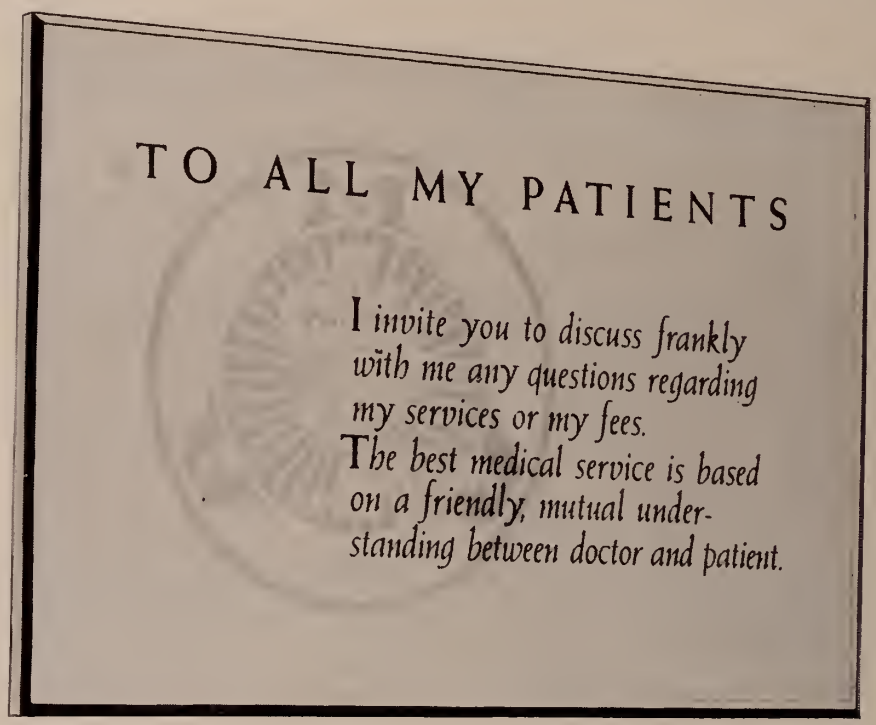
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '5
Florida Medical Districts	William C. Roberts, Panama City	Council Chairman	
A-Northwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Panama City, 1952
B-Northeast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Daytona Beach, 1952
C-Southwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	St. Petersburg, 1952
D-Southeast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Ft. Pierce, 1952
Florida Specialty Societies			
Academy of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	Hollywood, Apr. 27, '52
Allergy Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	" "
Anesthesiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
Chapter, Am. Coll. Chest Phys	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
Derm. and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
Health Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	
Industrial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	" "
Neurology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
Ophthal & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	" "
Orthopedic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	" "
Society of Pathology	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Laudardale	" "
Pediatric Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	" "
Proctologic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	" "
Radiological Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
Urological Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
Florida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 7, '52
Blood Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
Blue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 27, '52
Dental Society, State	John I. Todd, D.D.S., Jacksonville	Tom Price, D.D.S., Miami	Jacksonville, Apr. 20-23, '
Hospital Association	Charles C. Hillman, Miami	Mother Loretta Mary, Tampa	
Medical Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	Jacksonville, June 29-July
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 23-28,
Nurses Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16
Pharmaceutical Association, State	Mr. Euless Watford, Chipley	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-21,
Public Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct., '52
Tuberculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Pt. St. Joe	
Woman's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	Hollywood, Apr. 27-29, '5
American Medical Association	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Chicago, June 9-13, '52
A.M.A. Clinical Session	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
Southern Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, 1952
Alabama Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19,
Georgia, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 11-14, '52
G. E. Hospital Conference	Edwin B. Peel, Atlanta	Mr. R. G. Ramsey, Jr., Memphis	Atlanta, Apr. 16-18, '52
Southeastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath. B. MacInnis, Columbia, S. C.	Augusta, Ga., Mar. 21-22, '
Southeastern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	Boca Raton, Apr. 2-5, '52
Southeastern Surgical Congress	Joseph S. Stewart, Miami	B. T. Beasley, Atlanta	Atlanta, Mar. 10-13, '52
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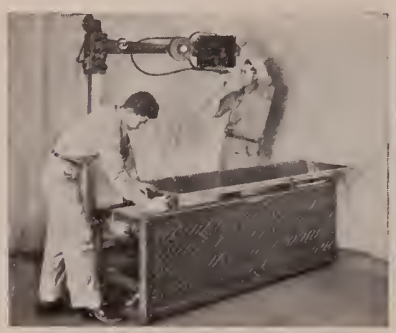
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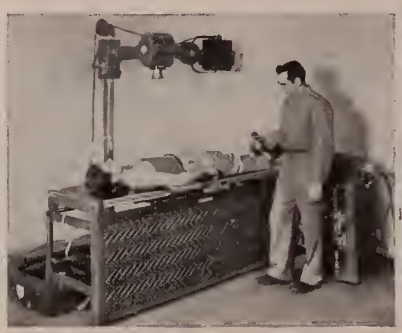
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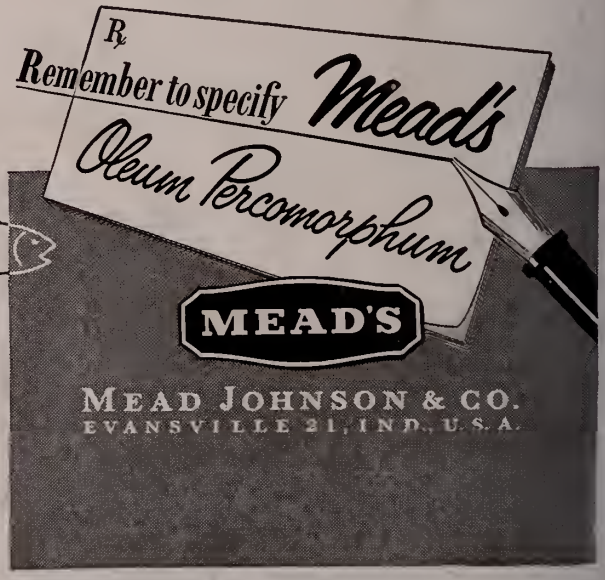


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DeWitt C. Daughtry and John G. Chesney

Corticotropin and Cortisone in Pulmonary Disease
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*Cutting, W. C.: A Manual of Clinical Therapeutics, ed. 2, Philadelphia, W. B. Saunders & Co., 1948, p. 484.

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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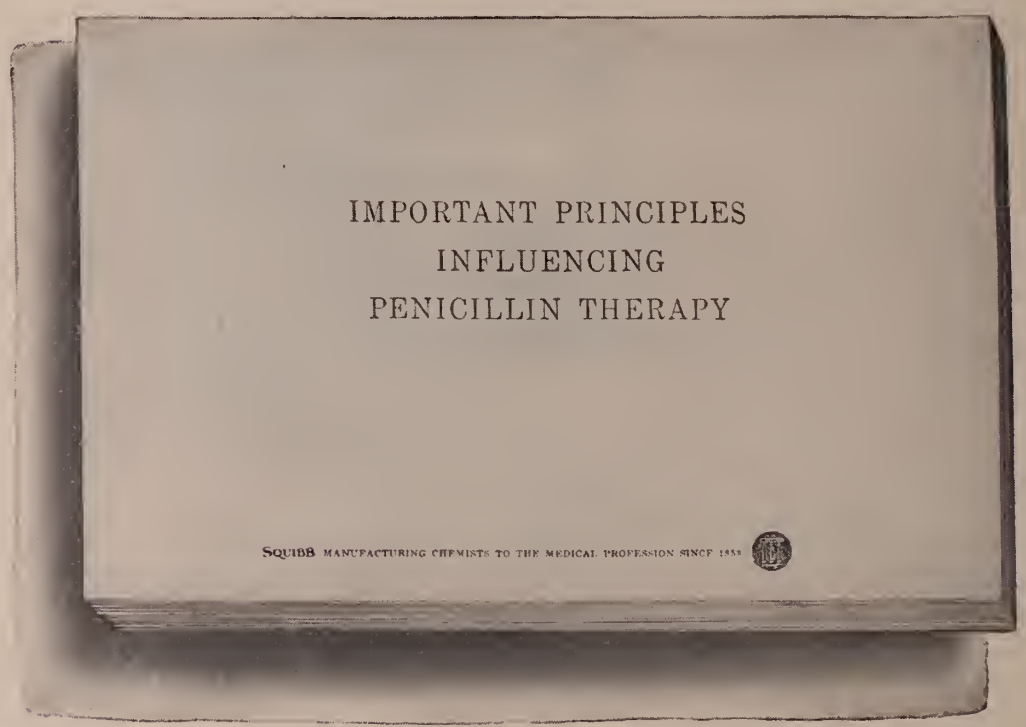
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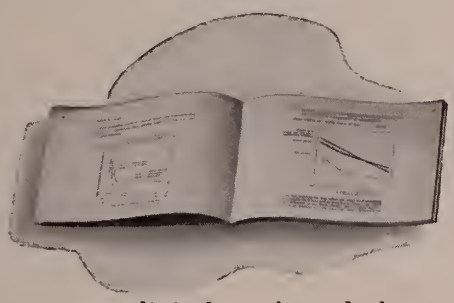
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NORCROSS, B. M., *N. Y. State J. Med.* 51: 2356, Oct. 15, 1951.

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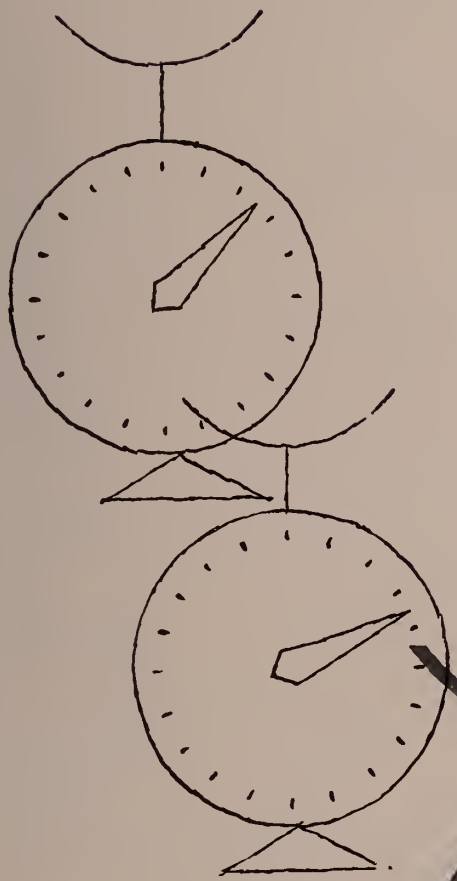
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1 Gardner, L. I., Butler, A. M., et al.: Pediatrics 5:228, 1950
2 Nesbit, H. T.: Texas State J. M. 38:551, 1943
3 Bull. National Research Council No. 119 Jan. 1950
4 Recommended Daily Dietary Allowances, Revised 1948, Food and Nutrition Board, National Research Council

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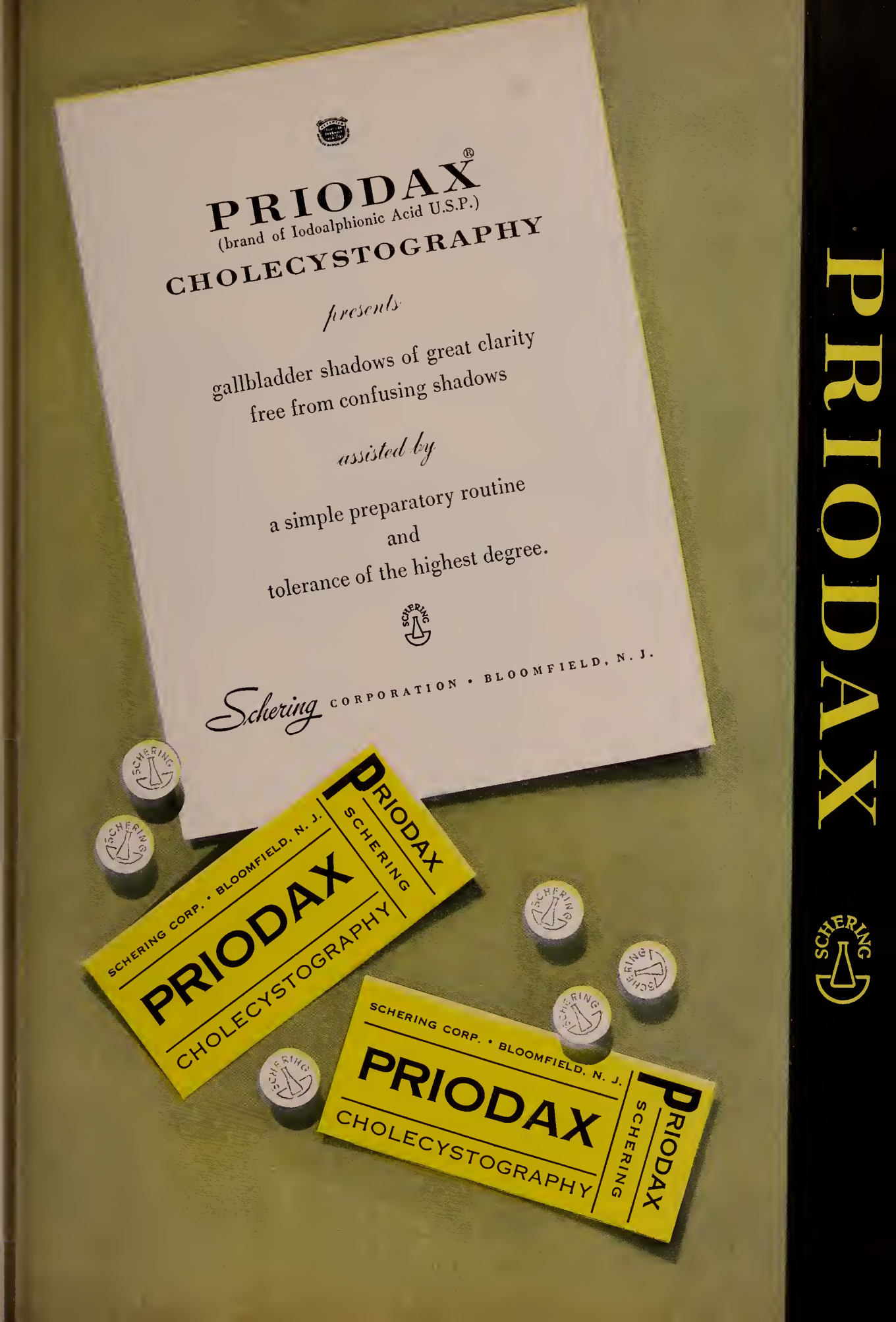
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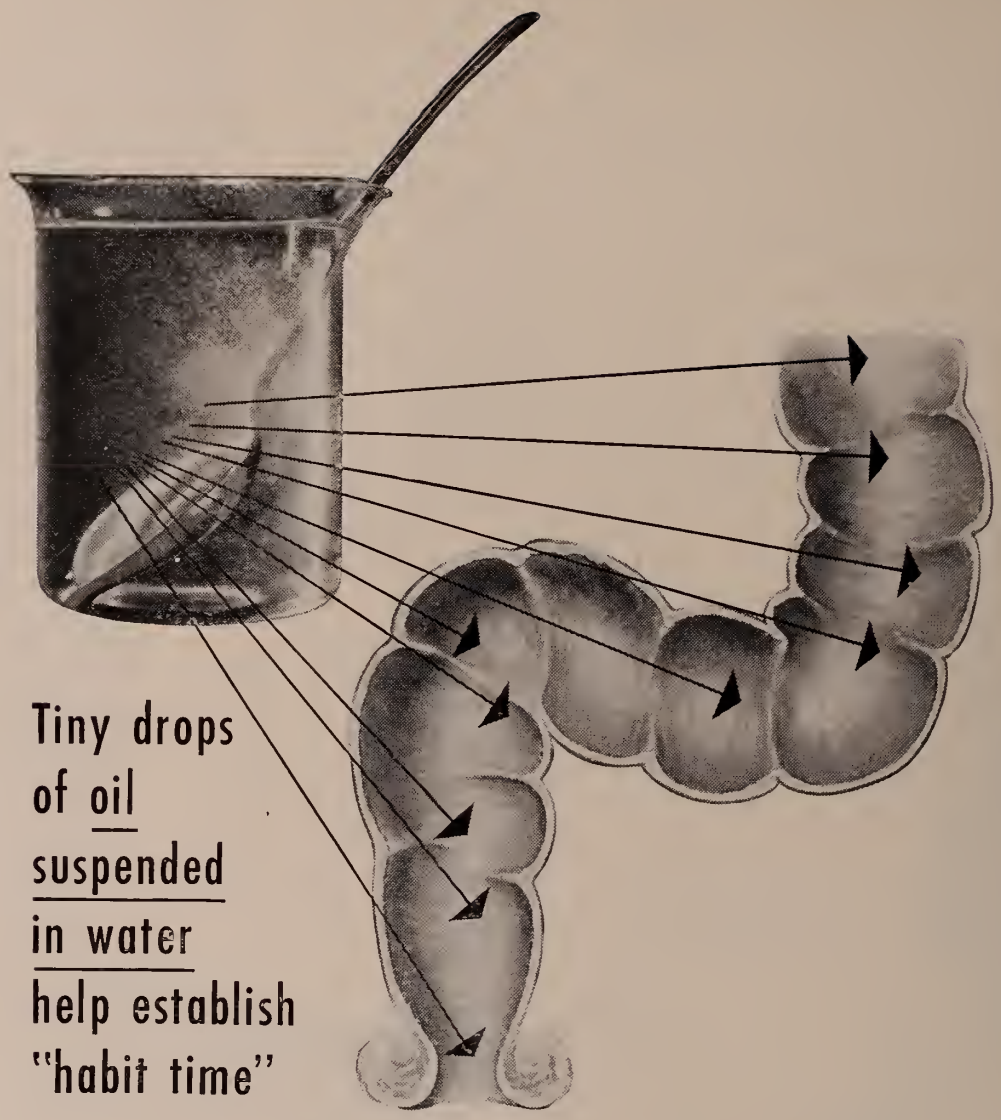
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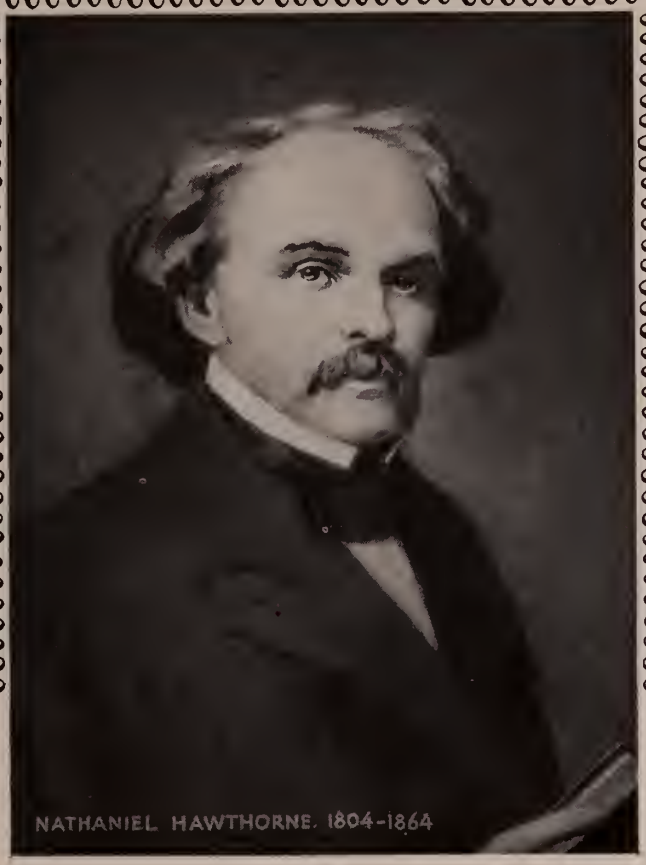
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**J.A.M.A. 146:35, 1951.*

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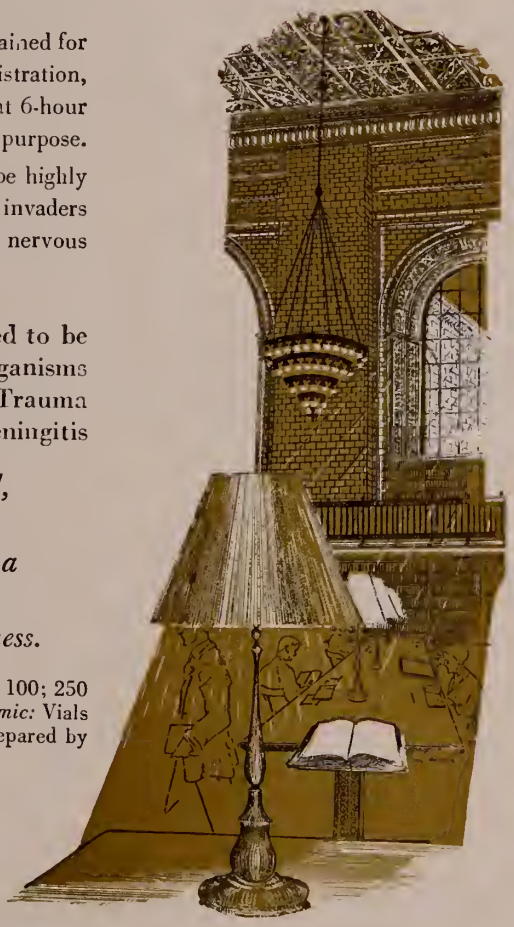
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXVIII | Jacksonville, Florida, February, 1952 | No. 8

Advancing Field of Thoracic Surgery

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AND
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MIAMI

Some of the most valuable and spectacular advances in the history of medicine have occurred recently in the field of thoracic surgery. It is interesting to recount the advances and to realize that almost the entire development of this field has occurred during the past three decades. The most dramatic developments have taken place during the latter half of this period. A majority of the surgeons who have made the fundamental contributions are still actively practicing surgery. The thoracic surgeon deserves only a small portion of the credit. Chemotherapeutic agents and antibiotics, better understanding of physiologic principles, widespread use of blood plasma and tremendous advances in anesthesia have played a great part in the development of this new and vast field of endeavor. He has devised many means of diagnosis, however, and has spent much time clarifying the previously hopelessly confused anatomy of the thorax. Three decades ago few surgeons dared open the living thorax for the general understanding was that an open thorax was synonymous with death.

In 1933, Graham performed the first successful pneumonectomy for carcinoma of the lung. It is dramatic to hear him relate the events leading to this procedure upon a fellow physician who would not submit to the pneumonectomy until he had had some dental bridgework done. The physician upon whom this first operation was performed is still actively engaged in the practice of medicine. Thoracotomy is now as common an occurrence in many of our larger hospitals as gastrectomy or resection of the colon. Early in the development of thoracic surgery, it was natural that only salvage type patients were operated upon. After improved technic and better over-all results were attained, and after the clarification of the indications, the field has expanded to include about as many procedures as are performed by the abdominal surgeon.

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 25, 1951.

Diagnostic Aids

Bronchoscopic examination, aside from radiologic study, is the single most important diagnostic procedure available to the thoracic surgeon. Its value is greatly enhanced when the surgeon is thoroughly conversant with thoracic disease, physiology, and living gross pathology of the chest, for it is now appreciated that there are many clues to pulmonary function as well as anatomic derangements to be derived. The technic itself has been extended with the addition of right angle foroblique and retrograde telescopes, and also by the development of cytologic diagnosis of malignant disease from bronchial washings.

Bronchography has undergone change and refinement in purpose. Whereas a filling demonstrating or excluding ectasia was formerly considered adequate, its goal has now become the accurate and complete study of each segmental bronchus. The result has been widespread improvement in bronchographic technic.

In addition, the harmful results of a cavalier attitude toward the instillation of iodized oil, if they are not, at least should be appreciated, for these oils in unsuitable cases are capable of producing a prolonged state of bronchitis and bronchial spasm with crippling dyspnea. In addition, nonbronchial diseases, inflammatory and neoplastic, are ill-advisedly obscured in subsequent roentgenograms. These latter objections may be met by the use of new, rapidly absorbed contrast mediums in aqueous solution for instillation or in powder form for insufflation. Introduced first in England, and about to be released commercially

here, these products are of value, but in highly accurate segmental studies, their efficacy is less than that of the present oily mediums.

Roentgen kymography is an accurate method for recording the pulsation of the heart, great vessels, and suspected aneurysms, and has been of particular use in studying constrictive pericarditis.

Angiocardiograms made after intravenous injection of diodrast, and cardiac catheterization studies yield accurate information as to cardiac function and anatomy.

Tomography or laminagraphy, though objectionable because of the expense of the equipment and of operation, is of considerable aid to the thoracic surgeon and internist, particularly in determining cavitation. It has also been shown to be the most accurate method of picking up small intrathoracic metastases which cannot be detected on routine and stereoscopic roentgenograms. This is of great importance in view of the increasing frequency with which thoracic surgeons are being called on to remove solitary metastases in the chest. In such cases, laminagraphy, if available, should be employed to rule out multiple metastases too small to appear on routine roentgenograms.

Roentgen studies following the induction of pneumoperitoneum, a procedure used by us for several years, is helpful in differentiating subdiaphragmatic from supradiaphragmatic lesions.

The greatest single advance has been the increasing appreciation of the importance of roentgenograms of the chest, even when physical signs are absent. The diminishing tendency to treat thoracic disease unguided by roentgen study has resulted in a steadily decreasing delay in diagnosis of all varieties of disease of the chest.

Surgery of the Lungs

With dwindling mortality and morbidity in surgery of the lungs, the picture of operating for "salvage" has changed to that of operating to relieve symptoms and disability early in the course of disease, and the variety of pathologic conditions that have been cured by pulmonary resection is endless. Pre-eminent, of course, is bronchogenic carcinoma. Increasingly early suspicion and rapidity of management by subjecting the patient in such cases to early bronchoscopy and exploratory thoracotomy are reflected in a steadily climbing operability and resectability rate. The outlook in this disease should not and will not under these circumstances remain as poor as heretofore.

During the last decade lobectomy for bronchiectasis became a most satisfactory procedure, and in many cases lobes were removed from each side in bilateral bronchiectasis. As experience increased, mortality dwindled, and now, in centers well equipped in staff and experience to manage these cases properly, it approaches 1 per cent. As the detailed intralobar anatomy was worked out, segmental resection of the modern type was developed. This procedure is of great help in bilateral bronchiectasis, allowing, as it does, the removal of only the involved portions while the healthy segments of the lobe are left in place. Two patients in our series had segments removed from four of the five lobes (fig. 1).

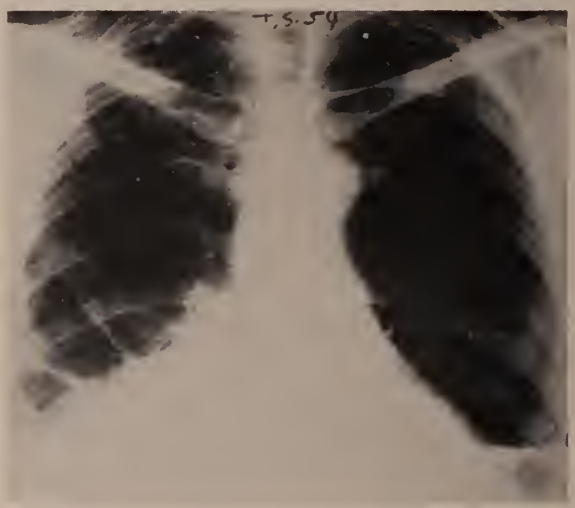


Fig. 1. — E. C., a man aged 35, had segments removed from four lobes for incapacitating bronchiectasis with good rehabilitation.

The tendency to drain abscesses, a life-saving procedure in former years, has changed greatly with the advent of the antibiotics. Vigorous medical measures will now commonly produce cure, and in the remaining cases cure may be effected by pulmonary resection. A related lesion, the congenital pulmonary cyst, which not infrequently produces pulmonary hemorrhage or becomes infected with the appearance of abscess of the lung, is also a relatively common lesion curable surgically.

Other intrapulmonary lesions which have been resected are endless in number, and each month brings reports of removal of some new tumor or inflammatory lesion. The commonest, however, are bronchial adenoma, tuberculoma, hamartoma or chondroma, arteriovenous aneurysm, and chronic granulomas of undetermined etiology. Pulmonary

adenomatosis, an apparent neoplasm or possible infectious process commonly of multicentric pulmonary origin, has recently been observed with increasing frequency.

Particular mention should be made of the surprisingly good results in resection for solitary pulmonary metastases occurring after removal of a primary neoplasm elsewhere in the body. Resection of solitary metastases from soft tissue sarcoma has yielded prolonged survival in a remarkably high proportion of the cases. Results with other sarcomas are also encouraging, and certain solitary metastatic carcinomas have been resected with occasional benefit.

Spontaneous pneumothorax with frequent recurrence is an indication for thoracoscopy for study of the pleural surface and, occasionally in younger persons, thoracotomy with resection of bleb-bearing segments or lobes, depending on the local situation.

When spontaneous pneumothorax occurs in aged persons with advanced emphysema, we have observed that pneumoperitoneum, introduced after re-expansion has occurred, serves the twofold purpose, first, of decreasing the all important residual air, thus improving respiration, and, secondly, of taking the strain off the visceral pleura, thus decreasing the chance of rupture.

Surgery of Mediastinal Tumors and Mediastinitis

Aside from lymphogranulomatous lesions of the mediastinum which can usually be diagnosed by their appearance, blood picture, node biopsy, and rapid melting within a week on a small test dose of irradiation, the common mediastinal tumors include dermoid cyst, teratoma, substernal thyroid, paramediastinal neurofibroma, pleuropericardial cyst, and less commonly, bronchogenic cyst, thymoma, lipoma and hyperplastic tuberculous nodes.

As a rule the resectability rate is high with complete cure, and, as the neoplasms mentioned all have a distinct tendency to become malignant, their prompt removal is usually advisable with the exception of the lymphogranulomas.

Mediastinitis is a disease that is increasing in frequency and commonly arises from esophageal perforation. Erosion or penetration by a foreign body may occasionally produce this situation, but far more commonly, unfortunately, the perforation is produced during esophagoscopy or dilatation. Skillful, and this implies careful, instrumentation should eliminate the majority of these tragic instances. When the telltale of pain in the back, the slightest cervical subcutaneous emphysema, minimal pleural effusion or pneumothorax occurs following esophagoscopy, extensive experience has proved that the only safe treatment is the administration of antibiotics, localization of the perforation by a swallow of iodized oil, and immediate drainage by cervical or posterior mediastinotomy. Sometimes an early perforation may be treated by primary closure if detected within the first few hours.

Spontaneous rupture is another esophageal lesion that has been diagnosed successfully a number of times. The pain, unlike that of perforation of a peptic ulcer, begins immediately after an attack of vomiting in contradistinction to the preexisting pain in peptic ulcer. There is frequently a history of consumption of much alcohol and most perforations have occurred while the patient, having a full stomach, vomited violently. The pain is agonizing and usually produces a boardlike abdomen, but unlike perforation associated with peptic ulcer, there is no air under the diaphragm. The appearance of a left pleural effusion and pneumothorax and, frequently, subcutaneous air at the sternal notch confirm the suspicion. The treatment is thoracotomy and immediate closure of the rent.

Diaphragmatic Hernia and Transdiaphragmatic Approach to the Upper Part of the Abdomen

The repair of diaphragmatic hernia is a common thoracic procedure, the chest approach giving unexcelled exposure and allowing ideal conditions for closure. The chief exception is the large posterior hernia in the newborn. In this condition it is technically easier to employ the abdominal approach, and the abdominal skin alone may be closed if necessary to ease the abdominal tension. Apropos of these remarks concerning exposure is the finding that the thoracic transdiaphragmatic approach often greatly eases the difficulty in removing a greatly enlarged spleen or kidney, while much gastric surgery and shunt operations for portal hypertension are facilitated.

Paraesophageal hiatus hernia with stasis and ulceration should be added to the list of causes of severe hematemesis. The loss may be acute or chronic and ceases when the constricted stomach pouch is released and returned to the abdomen.

At times, because of age or other factors, a hiatus hernia of small size may be considered unsuitable for reduction, in which case a left temporary phrenic crush, repeated at intervals upon

regeneration, is a valuable procedure by dint of the relaxation of the diaphragm. Permanent destruction of the nerve for such a situation is not warranted.

Surgery of the Heart

Although the removal of a constricting pericardium was accomplished in a comparatively modern manner by the German Schmieden in 1914, cardiac surgery underwent little advance in this country for many years, although shortly after World War I, a cardioscope was invented by Allen and used on dogs. In addition, about this time, Cutler operated upon 2 patients with mitral stenosis, converting the situation from one of stenosis to insufficiency. One of his patients experienced temporary betterment, but died within the year. The great surge of activity began again with the division of the ductus arteriosus by Gross[1] in 1939, which set the stage for a resurgence of interest in cardiac surgery. Shortly afterward came the well known contribution of Blalock[2] in tetralogy of Fallot and other congenital anomalies and the resection of a segment of aorta for coarctation which was first performed by Crafoord and Nylin[3] of Sweden.

At the present time, widespread research and clinical activity are directed toward the production and correction of interatrial and ventricular septal defects, and the conversion of stenotic valves into functioning ones by auricular, and ventricular approaches, a procedure applicable to both congenital derangements and the acquired lesions of rheumatic fever. There has been renewed interest in the development of cardioscopes to visualize and operate upon the interior of the chambers and valves. These instruments depend, in general, on pressure of the optical system against the object viewed to clear the field of blood, or upon intermittent jets of water associated with removal of blood to prevent cardiac strain. There are also numerous groups working on the problem of diversion of the blood past the heart by means of a mechanical heart and lung (extracorporeal circulation), the purpose being to allow, for a short period, direct surgical attack on the heart. Revascularization experiments depending on anastomosis of systemic arteries to the coronary sinus and burial of systemic arteries in the myocardium are also being carried out with some promise of success beginning to appear both in experimental animals and in man.

An important development just coming to hand is the development of arterial grafting already used with success by Gross, Bill and Peirce[4] in bridging the gap left in the aorta after resection of a long coarctation, and also successfully applied by Lam[5] in replacing a 6 inch segment of the thoracic aorta removed because of a saccular aneurysm. The result of this experience with grafts has led directly to the investigation of stored or bank grafts kept for varying periods of time in electrolyte solutions at various temperatures and the present preservation by lyophilization methods. The technical and legal pitfalls in the problem have been partially overcome, and the day of arterial banks has arrived. Progress toward the establishment of such a bank in the Miami area has been made.

The rarity of success by highly skillful, forward surgeons using such methods of bridging arterial gaps as the vein-lined tantalum tube during World War II is in great contrast with the high degree of success apparently possible with stored arterial grafts, and makes the working out of these problems and the development of such banks of particular importance in these uncertain times.

Surgery of the Esophagus

Long after the surgery of the remainder of the gastrointestinal tract had been developed to a high degree of perfection, the esophagus was considered too inaccessible an organ for surgical therapy in view of the great problems imposed. Among these in particular were its location in the thorax, and the peculiar blood supply of this organ which prevented resection and an anastomosis of the mobilized ends as in the intestines and colon. The modern type of resection of the esophagus for carcinoma was developed by Adams and Phemister[6] in the late thirties with lesions of the lower third of the esophagus.

Several years later, the stomach was mobilized sufficiently to allow the removal of a lesion at the aortic arch with anastomosis above the arch. It has now been demonstrated by a number of surgeons that the entire esophagus can be removed and the stomach may be brought up through the chest into the neck and anastomosed to the cervical esophagus or pharynx through a separate cervical incision. Despite the tremendous mobilization of the stomach necessary for such a transplantation, the blood supply remains adequate. A less widely known and utilized procedure developed by Wookey is applied in certain cases of the cervical esophagus in which the foregoing procedure is considered inadvisable, and in the Wookey procedure



Fig. 2. — C. H., a man aged 63. A. Carcinoma, middle third of the esophagus. B. After esophageal resection and supra-aortic esophagogastrostomy.

the cervical esophagus and tumor are removed leaving a cervical pharyngostomy and esophagostomy, the continuity of the esophagus being reestablished by buried skin tubes partially produced at the initial operation and closed at a second (fig. 2).

Another esophageal lesion now occasionally submitted to surgery with good initial results is the persistent cardiospasm that fails to respond to dilatation. In cases of this type an esophagastric plastic procedure has been used to good advantage in correcting obstructions, and in our hands immediate results have been generally good. Long term results are not yet available though peptic esophagitis with bleeding has been reported by others.

Congenital atresia of the esophagus with tracheoesophageal fistula in the newborn, a condition with a hopeless prognosis, is now correctible provided the diagnosis, which is readily made, is arrived at promptly and the infant is brought to surgery within the first few days of life. The condition demands division and closure of the tracheoesophageal fistula with mobilization and anastomosis of the proximal and distal segments of the esophagus. This procedure has completely replaced the multiple stage fashioning of anterior thoracic skin tubes leading from a pharyngostomy to a gastrostomy. In our opinion the right extrapleural approach of Haight and Towsley[7] used in their historic first case in 1943 or its various modifications offer greater safety in the event of anastomotic leakage than the transpleural approach. The technical problems are somewhat greater, but the increased safety in the event of leakage makes it well worth while.

If choking on the first feeding associated with cyanosis occurs in the newborn, this condition should be immediately suspected. It can be confirmed at once by demonstrating high obstruction of the esophagus by simply introducing a gavage tube. If obstruction is present, its location can be confirmed by roentgen examination with the tube in place, and all efforts then should be directed toward saving time, for with each hour the infant's condition can only become worse. Lipiodol, never barium, studies should be left for the surgeon, to avoid necessity for duplicate procedures and possible spill of lipiodol into the lungs. Though relatively rare, this condition is usually easily recognized, and every physician privileged to see treatment carried out successfully in such a case has a most satisfying experience (fig. 3).





Fig. 3.—Baby C. O., a girl aged 44 hours. A. Roentgenogram made immediately preoperatively with congenital atresia of the esophagus and tracheoesophageal fistula. The catheter demonstrates the obstruction. Note the air in the intestinal tract. B. Progressing normally at the age of 3 weeks. Note the scar.

Surgery of the Chest Wall

A number of years ago the foregoing title would undoubtedly signify thoracoplasty and various methods of drainage of empyema. We believe that it is within the limits and scope of this paper to skip past these well understood and still useful procedures to discuss the increasing number of benign and malignant tumors of the chest wall coming to the attention of thoracic surgeons. These are chiefly chondroma, osteochondroma and chondrosarcoma. It is our conclusion after observing a number of unfortunate results of expectant treatment that, probably, the long present, clinically benign, tumor of this type should be viewed with concern, whether growing or not. That it begins to grow and pursue a malignant course has been demonstrated on a number of occasions in our experience in which a presumably generous biopsy had revealed benign tissue. The development of growth in such a tumor, in our opinion, should be considered evidence of transition into a malignant lesion and constitutes indication for excision with a generous margin of normal tissue. In tumors of this type which have been long present and show no sign of growth, it is nevertheless our intention in the future to recommend resection, for the mortality and morbidity of such a procedure before the mass has attained large size is practically nil and the danger of malignant change is obviated.

Pectus excavatum (funnel chest) is a disabling defect when of moderate severity and is relatively easily corrected in infancy by division of the xiphosternal attachments and substernal ligaments. The pronounced retraction of the lower portion of the sternum when the infant cries is due to the short central tendon of the diaphragm, and, as growth continues, its effect is to draw the sternum dorsally, displacing the heart to the left and embarrassing its function. Another common complication of the condition is a tendency toward repeated pulmonary infections and bronchiectasis. Surgical correction, readily accomplished, with excellent results in infancy, is a formidable but well worth while procedure later, it being necessary at

this stage to resect extensively the deformed cartilages and elevate the sternum temporarily by traction (fig. 4).

Trauma of the Thorax

The severely damaged thorax with multiple broken ribs, abnormal mobility and paradoxic movement on respiration, pneumothorax and hemothorax, and contusion of the lung is a not uncommon problem in this age of speed. There are few conditions that require more of the surgeon's time than these injuries, but, by vigorous treatment with constant attention and checks upon the various specific conditions contributing to the patient's precarious state, in a remarkably high percentage of what formerly were commonly considered hopeless cases the patient may be restored to health. Blood is aspirated from the chest and replaced by transfusion while an intercostal catheter with water seal is used to treat pneumothorax when present. Sucking wounds are, of course, closed promptly and support, but never constriction, is applied to the mobile chest wall.

At times, it has been advantageous in our practice to expose and wire a number of fractures, a procedure which, when applied in the proper cases, causes great betterment, in ability to cough, in respiration, and in relief of pain. As the common cause of death in these cases is the overwhelming retention of bronchial secretions and blood, the energetic, repeated application of catheter suction of the bronchi, with bronchoscopic aspiration as needed, is often the most important aid to recovery. This technic is taught to all residents caring for thoracic surgical patients, and the skill with which they have applied this knowledge has resulted in the survival of a number of patients who otherwise would assuredly have died.

An additional factor of considerable value is the diminution of pain by intercostal block, thereby allowing the patient to cough more effectively. Yet another factor of importance is the realization that the effects of the injury have not reached their maximum as soon as the period of initial shock is corrected. The initial roentgenogram of the chest taken immediately upon admission to the hospital frequently shows minimal changes and should be looked upon as a base line for further study. Later roentgenograms may show the development of the



Fig. 4. — R. G., a boy aged 5. A. Severe funnel chest producing dyspnea and cardiac murmur due to mediastinal distortion. B. Surgical correction by an extensive chondrectomy and elevation of the sternum.

serious complications mentioned, and a policy of re-examination daily for about three days is a wise precaution (fig. 5).



Fig. 5. — H. S., a man aged 70. Roentgenogram shows multiple rib fractures reduced and wired for extreme mobility and paradoxic movement of chest wall.

Empyema

This nearly forgotten disease still exists. Antibiotics have successfully cleared empyema when aspirated and irrigated with penicillin, but in most cases eventually drainage is required after reduction in size by the method of aspiration and irrigation. Now, as in the past, the best results are obtained before massive pleural thickening has occurred.

Surgery in Tuberculosis

Along with Graham's contribution to thoracic surgery with his pneumonectomy for carcinoma stands the monumental contribution of Alexander,[8] who modified and remodified the thoracoplasty of Sauerbruch and developed years ago what is basically the modern thoracoplasty of today, making thoracic surgery an important phase in the treatment of pulmonary tuberculosis. Still a tremendously useful procedure, thoracoplasty entails negligible risk, and its results are a high rate of sputum conversion. In recent years, aided by discovery of streptomycin and by improved operative technic, the principle of resection has been applied to tuberculosis in the form of pneumonectomy, lobectomy, and in the past four years, segmental resection. The key to the safety in segmental resection, in addition to correct surgical technic, has been found to lie in the immediate re-expansion of the remaining lung postoperatively. With proper and vigorous postoperative care this procedure has proved safe and remarkably uncomplicated. The preservation of pulmonary functions by the use of this technic has, of course, been its outstanding attribute.

One particular type of tuberculous lesion might be especially stressed for its benignity should always be doubted. This is the solid round or coin lesion, commonly called a tuberculoma. Lesions of this type are frequently tuberculous cavities choked with tuberculous pus and capable of breaking down to produce a spread of the disease. Not uncommonly, however, they are actually early bronchogenic carcinomas. The wisest treatment is biopsy by segmental resection and further resection as indicated, should the gross appearance and frozen section examination reveal malignancy (fig. 6).

Conclusion

Retarded in its development by the complexity of the problem of operating within the open chest, thoracic surgery has now attained a position of great practical application. With the surgery of the other organs of the chest well advanced, it is probable that the last organ to be submitted to direct surgical therapy, the heart, will, within the next few years, become the field of greatly increased and beneficial operations.

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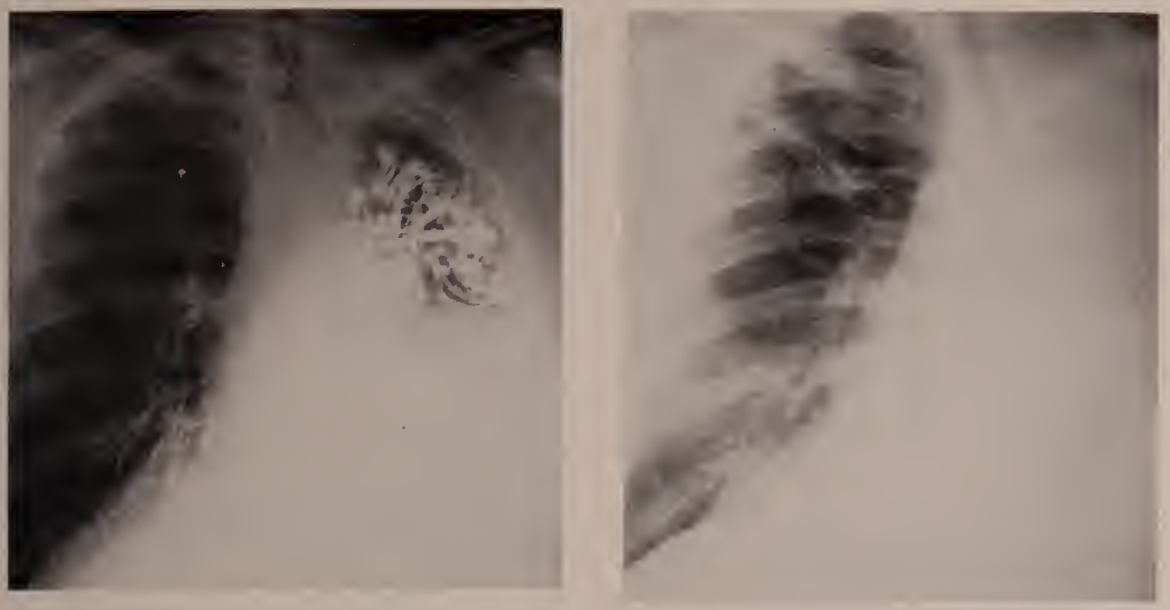


Fig. 6. — H. C., a man aged 40. A. Inactive tuberculosis, left, with extreme secondary bronchiectasis (destroyed lung). B. Postoperative status — free of cough and expectoration after pneumonectomy and concomitant thoracoplasty.

Discussion

Dr. John G. Chesney, Miami: I believe the advances in this field illustrate the importance of medical organization. To go back to the status of surgery of the chest in 1917, toward the close of the war, there was no background for advance in thoracic surgery as there had been in general surgery. Any surgery, it is trite to say, requires a strong background in physiology and pathology and anatomy. When one considers the textbooks and the literature of that day in the field of thoracic physiology, one realizes that it was only basic in its extent and there was little application to clinical thoracic disease. Pathology, gross pathology, was well developed, and microscopic pathology of the chest was well developed, but it was not supplemented with dynamic pathology. Roentgenology was also in its infancy, and the course of thoracic disease was not understood. One need only refer to Gray's Anatomy of those days to see the paucity of material available to the surgeon who might conceivably think of some day removing a lobe or a lung. There was practically no intrapulmonary anatomy described other than the eparterial bronchus.

The world war experience of numerous surgeons, particularly the German surgeon Sauerbruch, gave initial impetus to the development of thoracic surgery. Bulky and unwieldy apparatus occupying half a room for the management of the pneumothorax that would occur during an open thoracotomy was developed. Positive pressure anesthesia, as we know it today, was a long way off. In 1917 a number of surgeons who had operated on the chest met at the instigation of Dr. Howard Lilienthal in New York and formed a small society which eventually became the Society for Thoracic Surgery. For a number of years this society met annually and published its transactions in a portion of a single copy of the Annals of Surgery allotted to it every year. The impetus that was given to thoracic surgery and the study of anatomy and pathology and physiology of the chest by these meetings was tremendous. As a result of their investigation, much of which was animal experimentation, in 1933 Dr. Graham, using reasonable assumptions that had been gained since the war, successfully performed the first pneumonectomy for carcinoma and opened the field of intrapulmonary surgery. I think that there is a great lesson to be learned here, for this medical society, above all, took this field of surgery from a state of nothingness and in the period from about 1920 to 1950 brought it to the point where the variety of procedures performed within the chest rivals in number those performed by the general surgeon.

To go over Dr. Daughtry's summary of the clinical field, there are a few items to which I should like to say amen. I mention first the tracheoesophageal fistula, which I think he covered completely, but which will always bear repeating. Infants in whom this abnormality is diagnosed within the first day or two of life can be taken to the operating room, operated on for three or three and a half hours with anesthesia expertly administered, and closure of the fistula with end to end anastomosis of the esophagus can be carried out without striking ill effects on the baby. The mortality rate has dwindled in many instances to under 20 per cent. This procedure takes the place of the old operation of the construction of skin tubes over the anterior portion of the thorax, a multiple stage procedure that was usually never finished before the child was perhaps 8 years old, if he survived.

The second item is the early correction of the funnel chest. The funnel chest is a most disabling process, which becomes progressively worse as the child develops. It should be corrected early in life, probably preferably under the first year, and such a plan of course demands considerable foresight on the part of the child's doctor because at that time the lesion is not as severe as it will be later. This highly crippling abnormality progresses and requires excessive surgery to correct it at a later date.

Dr. Daughtry, concluding: I thank Dr. Chesney for his remarks.

Experiences with Corticotropin and Cortisone in Pulmonary Disease

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The discovery and production of pituitary adrenocorticotropic hormone and cortisone have opened a new chapter in therapeutics, if we are to judge by their extensive use in a wide variety of diseased states. The early release of these agents to the profession before adequate clinical experience could be obtained has placed upon it a heavy burden of responsibility for determining the usefulness and dangers of these substances in clinical medicine. These responsibilities stand out in bold relief when one examines the broad spectrum of action of these hormones. Briefly, many of the actions that are known may be considered under several subdivisions:

1. Hemopoietic System: Eosinophils decreased; lymphocytes decreased; platelets increased; polymorphonuclears increased; elevated sedimentation rate decreased; elevated globulin decreased; blood coagulability increased.
2. Kidneys: Renal threshold decrease with tendency to glycosuria and increased clearance of uric acid.
3. Enzymes: Lysozyme altered; all other enzymes decreased.
4. Cellular Structure: Inhibition of toxic action by bacterial ducts, antigens, or chemicals; tuberculin sensitivity inhibited; cell permeability decreased; fibroblastic proliferation checked.
5. Central Nervous System: Pain inhibited; fever reduced; euphoria; change in psyche; psychotic manifestations may occur.
6. Endocrine System: Increased glucogenesis in carbohydrate metabolism; diabetic state may occur; produce adrenal cortical depression.

These widely divergent effects indicate that although corticotropin and cortisone may have a wide field of usefulness, they may also be the cause of dangerous physiologic alterations.

The effects of these hormones on pulmonary diseases have been widely reported.[1-6] Early publications were highly enthusiastic about the results in such conditions as asthma, pneumonia, and even tuberculosis.[1,2,6,8] In later reports,[3-5,7] doubt and skepticism as to the value of these agents have crept in. As yet there appears to be no unanimity of opinion as to the proper place of these agents in the treatment of the various pulmonary diseases. Our contribution towards this goal is a report of our observations in 16 cases. There were 9 cases of bronchial asthma, 2 cases of asthma complicated by extensive pulmonary fibrosis and emphysema, 1 case of interstitial pulmonary fibrosis, 1 case of pulmonary emphysema, 1 case of pulmonary granulomatosis, and 2 cases of severe fulminating pneumonia. The following brief case reports summarize our experiences with the use of these hormones:

Report of Cases

Case 1. — J. H., a 50 year old white man, had had nonseasonal asthma, rheumatoid arthritis and spondylitis for seven years. Little response was obtained with aminophylline, potassium iodide and aerosol therapy over a period of three weeks. Cortisone was given for twelve days for a total dose of 2,000 mg. No change in the clinical picture was observed. Cough and wheezing persisted, and the arthritis was unchanged.

Case 2. — N. C., a 37 year old white woman, had had hay fever for twenty-five years, asthma for one and a

Read before the Medical Section of the Florida Tuberculosis and Health Association, Palm Beach, April 5, 1951.
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Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.
This study was encouraged by Dr. Leonard G. Rowntree, Chief Consultant, Pratt General Hospital, Coral Gables.

half years and periarteritis nodosa. Continuous wheezing, fever, leukocytosis and eosinophilia were present. Muscle biopsy gave negative results. The Thorn test with ACTH produced a 15 per cent fall in circulating eosinophils. ACTH, 80 mg., was given daily, and subsequently the dose was decreased to 10 mg. The patient was treated for eighteen days. She became symptom-free on the fourth day with normal temperature and white blood cell and differential counts. She did not return for follow-up, but reported she was not doing well six months later.

Case 3. — L. S., a 39 year old white man, had suffered from nonseasonal asthma for eighteen years. Frequent repeated attacks were most disabling with only transitory relief on routine therapy. Cortisone, 1,400 mg., was given over a period of two weeks. Excellent results were obtained by the sixth day and maintained on 50 mg. daily. There was considerable gain in weight. The asthma returned one month later and was not relieved on 25 mg. of cortisone daily. The condition gradually worsened into severe status.

Case 4. — S. F., a 29 year old white man with nonseasonal asthma for seven years, was totally disabled by daily attacks. The vital capacity was 56 per cent of normal, and the Thorn test with ACTH gave a 60 per cent drop in eosinophils. ACTH, 80 mg. daily decreasing to 10 mg. over a period of twenty days, was prescribed. Excellent response occurred with the lungs clear by the fourth day. The vital capacity was 112 per cent in the third week. Buffalo obesity, mooning and pigmentation were noted. Three days after the stopping of ACTH, asthma recurred in severe form and was difficult to control. The side reactions disappeared by the third month.

Case 5. — I. D. M., a 25 year old white man with nonseasonal asthma for five years complicated by bronchiectasis, was totally disabled with frequent attacks of status asthmaticus. His vital capacity was 46 per cent of normal. There was a hostility to physicians and nurses on the ward. Cortisone, 1,400 mg. over a period of two weeks, was given with excellent response. The lungs were clear by the eighth day, the vital capacity was 110 per cent at the end of this period, and the emotional outlook was favorable. Maintenance therapy with 25 mg. daily was continued. There was no recurrence after two months.

Case 6. — E. S., a 56 year old white woman, had had hay fever for thirty years and nonseasonal asthma for ten years with almost daily episodes of severe asthma. Cortisone, 200 mg. daily, was given at the start and reduced to 12 mg. orally every other day for two weeks. There was prompt sustained relief with occasional mild asthmatic episodes on maintenance therapy.

Case 7. — G. M., a 23 year old white woman, had had seasonal winter asthma for four years. The severe recurrent episodes responded poorly to routine therapy. Cortisone was given for three weeks. There was a prompt remission, but relapse occurred despite increase of the maintenance dose up to 50 mg. daily. ACTH was substituted with better results with only mild asthma for four months on a maintenance dose of 10 to 15 mg. daily or every other day.

Case 8. — P. G., a 22 year old white woman, had suffered from nonseasonal asthma since childhood. The severe episodes responded poorly to routine therapy with frequent bouts of status asthmaticus. Treatment was started with cortisone, 200 mg. daily. A total dose of 2,600 mg. over a six weeks' period was given. There was a good remission for six weeks on 25 mg. of cortisone as a maintenance dose. The asthma then gradually worsened despite increase of the cortisone to 100 mg. daily, ending in severe status asthmaticus and exfoliative dermatitis.

Case 9. — D. F., a 58 year old white woman, complained of nonseasonal asthma and chronic bronchitis with pulmonary emphysema of twenty years' duration. She suffered severe episodes of chronic asthma with periods of remission in warmer weather. Cortisone was given for two weeks, total dose 2,000 mg. There was only slight improvement, and ACTH was substituted, 1,000 mg. being given over the following two weeks. There was moderately good response, but cough and expectoration continued. The asthma was held in check for two months, but then recurred although it was not as severe as were the previous frequent attacks.

Case 10. — W. W., a 60 year old white man with old healed tuberculosis and bronchial asthma for the past fifteen years, had in the past four months experienced pronounced dyspnea in addition to the severe asthma. The Thorn test gave a 60 per cent drop in eosinophils. ACTH, 80 mg. daily, was prescribed, then reduced to 10 mg. after the fourth day. There was great subjective improvement, euphoria and reduction of the cough and expectoration. Pigmentation occurred together with gain in weight. The remission lasted six weeks. Symptoms recurred with the onset of cold weather.

Case 11. — G. F., a 50 year old white woman of psychopathic personality who had had infectious asthma for the past twenty years was admitted to the hospital in severe respiratory distress. Cortisone, 200 mg. daily for two days, was prescribed. There was no effect on the asthma. There was a pronounced hostile reaction, necessitating transfer of the patient to a mental institution.

Case 12. — M. E., a 58 year old white man with interstitial pulmonary fibrosis and cor pulmonale of eleven years' duration, experienced increasing cough and dyspnea. Roentgen examination showed diffuse parenchymal mottling. Routine treatment for cor pulmonale was ineffectual. Cortisone, 1,300 mg. over a period of two weeks, was given with prompt and excellent subjective relief of the symptoms. A maintenance dose of 50 mg. every other day was continued for two more weeks. Roentgenograms showed no change. The patient was transferred to another hospital for continuation of treatment, but cortisone was not continued there, and the patient had a recurrence of his initial symptoms.

Case 13. — C. K., a 49 year old white man who had had pulmonary emphysema and cor pulmonale over a period of twenty years, showed little improvement on digitalis, vasodilators, salt-free diet and diuretics. ACTH, 60 mg., was given daily for five days with no improvement in pulmonary function. The patient died two weeks later of a myocardial infarction.

Case 14. — L. H., a 24 year old white man, was admitted to the hospital with consolidation of the right lung. The onset was with pleurisy, and anaerobic streptococci were obtained on culture from the sputum. The patient was acutely ill with cyanosis, tachypnea and fever of 104 F. An initial pleural tap failed to yield any fluid. In addition to penicillin, streptomycin and aureomycin, the patient was given 1,000 mg. of cortisone over a period of five days. Improvement occurred on the fourth day of this treatment with reduction in fever and toxicity, but this continued even after the withdrawal of the cortisone. Empyema developed on the tenth day, necessitating thoracotomy on the twentieth day with good recovery.

Case 15. — H. M., a 37 year old white man, was admitted to the hospital with alcoholic hallucinosis and signs of acute suppurative disease of the lung. He was highly toxic, febrile and in a critical state. In addition to routine antibiotic therapy, he was started on 200 mg. of cortisone daily on the third day of his admission, and this therapy was continued for six days. His condition continued unchanged for one week, following which there occurred a gradual defervescence and clearing of the hallucinosis. The entire pulmonary condition cleared after four weeks.

Case 16. — H. S., a 54 year old white man, experienced an illness which was diagnosed as pulmonary granulomatosis of undetermined etiology and ran a febrile course of several months' duration. Roentgenograms revealed extensive involvement of both lung fields. There were severe cough and expectoration, dyspnea, and elevated white blood cell count and sedimentation rate. He received 1,200 mg. of ACTH over a three weeks' period, then 75 mg. of cortisone daily for one week, subsequently reduced to 25 mg. There was a subjective decrease in cough and expectoration while on this therapy, but the patient complained of insomnia, restlessness, loss of libido and skin bronzing. With withdrawal of therapy there was recurrence of symptoms. There was little change in the roentgen picture.

Discussion

Classifying the results as immediate and late enabled us better to evaluate the effects of these agents. Nine of the patients showed a good initial response as noted by a prompt improvement in the clinical picture. In case 2 the lack of correlation between the eosinophil response, as determined by the Thorn test,[9] and the clinical course should be noted. This has been commented on by others.[10] Eight of these patients were asthmatic, and the other had interstitial pulmonary fibrosis. Of the total of 16 patients, 7 showed no response. Three of these were asthmatic. The other 4 included 2 patients with severe fulminating pneumonia, complicated by abscess in 1 and empyema in the other, both improving slowly under the influence of antibiotic therapy; 1 patient with pulmonary emphysema; and 1 with pulmonary granulomatosis, who showed temporary subjective improvement, but the therapy must also be considered a failure as regards the change in the underlying pulmonary disease.

A follow-up of the 9 patients who showed an initial favorable response revealed even more discouraging results. In only 3 was the remission sustained during this period of observation. One was followed for two months and then lost sight of. Two are free of severe symptoms as long as they continue the use of the drug. One employs 25 mg. of cortisone and the other 10 mg. of pituitary adrenocorticotropic hormone daily (cases 5 and 7). Stopping treatment for a few days results in a recurrence of severe asthma. They have been on this regimen for approximately four months. Six of the initially improved patients suffered relapse within three days to two months after discontinuing the hormones. In 2 of these the rebound of symptoms appeared to be more intense than the original attack. An attempt to procure a second remission in some of these by reinstituting therapy proved futile.

Added to the uncertain therapeutic responses were troublesome and often alarming side reactions. These included insomnia, restlessness, suppression of libido, edema, mooning and buffalo obesity, excessive pigmentation and bronzing of the skin, and a psychotic episode. Four sequelae, coronary occlusion, severe exfoliative dermatitis, empyema, and pulmonary abscess, may not have been related to the hormone therapy employed, but in view of our incomplete knowledge of these agents, they justify mention. Shick, Baggenstoss and Polley[11] reported occlusive phenomena on autopsy material in cases treated with these agents, and the tendency of these drugs to interfere in some manner with the natural containment of infections by body defense mechanisms is well known. The withdrawal of these agents is no guarantee that the side reactions will subside promptly. We suspect that in 3 of our cases, 7, 8, and 16, they became intensified. The extreme bronzing noted in 2 cases, 8 and 16, appeared in patients previously tanned by the sun, and became progressively deeper despite the fact that they were removed from further exposure and the drug was gradually discontinued.

The exact mechanism of action of these hormones in diseased states is still uncertain. Their effect in asthma does not appear to be due to a blockage of histamine.[12] In infectious processes there seems to be also a central action, as noted by a sense of well-being and a reduction of fever without a concomitant change in the local process. But simple relief of pain, reduction of the febrile course, and the production of euphoria are not good therapy if the morphologic state remains unaltered. Hench, Kendall, Slocumb and Polley[13] stated that in no condition is the etiologic agent influenced by these hormones. It is only the tissue reaction that is affected. When these tissue changes are harmful and disabling, their correction may favorably influence the diseased state. When they are necessary for the natural healing processes or the containment of noxious agents, their elimination may prove harmful. Absence of phagocytosis and inhibition of fibroblastic response may result in deleterious effects on the disease process.

Summary and Conclusions

Sixteen patients with various pulmonary lesions were treated with pituitary adrenocorticotropic hormone and cortisone. Relief of symptoms was obtained in 9, or slightly more than 50 per cent, but the majority of these experienced relapse in a comparatively short period of time. In chronic and recurrent pulmonary conditions such as asthma, temporary relief may often be obtained with these hormones, but the rebound of symptoms is so common that one should exhaust every avenue of conventional treatment before resorting to these drugs. For severe acute pulmonary conditions with grave prognostic signs, when accepted therapy has failed, these agents may be employed with caution. But even here their use is warranted only on the basis of clinical research and a realization of their pro-

found effects and dangers. Until further studies reveal more fully the mechanism of their action, the cause of resistance to their prolonged use, and the means of avoiding or counteracting the undesirable side reactions, we must consider them unsuitable for the routine treatment of pulmonary diseases.

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The Fragile Male

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Physicians and laymen alike are familiar with the fact that the present life expectancy at birth for females is considerably greater than that for males, the latest figures being 64.7 years and 70.2 years respectively. Many of us have ascribed this to the fact that deaths more often affect males, as a result of military action, accidents and homicides, and have not realized that the matter goes much deeper. According to the National Office of Vital Statistics there has been a considerable difference in mortality between the sexes at least since 1900; and since World War I the differential in the death rate between males and females has become progressively greater. For example, in 1926 the age adjusted death rate for males was a little more than 14 per cent higher than that for females, whereas by 1948 the difference had increased to 41 per cent. The death rate for females in the United States decreased 13 per cent from 1940 to 1949 while the death rate for males decreased only 7 per cent. According to mortality figures for the United States for the year 1949, these sex differences in mortality are apparent and definite in every age group. For instance, in 1949 the death rate for infants under 1 year of age was 38.3 per 1,000 for males and 29.5 per 1,000 for females, the male death rate being 30 per cent higher than that for females. At the other end of the age scale, the death rate for males 75 years of age and over was 123.8 as compared to 104.2 for females. Also, it appears that the greater weakness of the male appears even before birth since in 1949 there were 10,353 deaths from congenital malformations amongst males as compared to 8,339 among females. In order to show the breadth of the problem the number of deaths by sex from several major disease conditions is given in table 1.

Similar figures are shown for Florida in 1949. Of 643 deaths occurring from tuberculosis, 424 occurred in males and 219 in females. Of 13 deaths occurring from poliomyelitis, 10 were in males. Of a total of 25,317 deaths occurring in 1949, 14,974, or about 60 per cent, occurred in males. One naturally wonders, if males die at a greater rate, why there is not a greater inequality in the sex distribution of the population. The fact that there is at present no great inequality in so far as the total population is concerned is shown

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by the fact that the population of the United States (United States Bureau of the Census estimate) as of July 1, 1948 was 146,571,000 of whom 72,969,000 were male and 73,602,000 were female. One would expect that with such a differential in mortality there would be a vast difference in the number of female survivors in the older age groups. Of an estimated population of 446,000, 85 years of age and over in 1948, 191,000 were male and 255,000 were female. Nature in some subtle manner seems to arrange for a fairly equal distribution of the sexes by causing more male babies to be born.

In Florida for instance, in 1949 there were 106.2 male births per 100 female births. It is interesting also to note that there were 108.0 white male births per 100 white female births, as compared to 101.9 Negro male births per 100 Negro female births. Incidentally, the differential between male and female mortality in the Negro population in the United States is less pronounced than in the white population. Although males are born in greater numbers, their higher death rate brings the two sexes to about equal numbers at around age 20, and thereafter females are in the majority. Females have a substantially greater mortality rate from diabetes and about the same death rate from cancer. Deaths incident to childbirth have become almost negligible in the over-all picture in the United States and in Florida in recent years. In 1950 only 83 deaths from this cause occurred in Florida out of a total of 26,533 deaths. Since deaths incident to childbirth are becoming progressively more rare, and deaths from diabetes are preventable in a large proportion of cases, and since the major types of cancer causing death among women are those of the breast and cervix which are more susceptible to treatment than other types of cancer, it appears that the outlook for further decreases in mortality is more favorable for the female than for the male.

Every practicing physician should give considerable thought to this problem. Much special effort in the past has been devoted to the care and treatment of women. The time has arrived for the medical profession to investigate the problem and determine whether or not more attention should not be paid to the health of the weaker of the sexes.

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Table 1.—Deaths from Specified Causes in the United States, 1949

Cause of Death	Both Sexes	Male	Female
All causes	1,446,000	824,220	621,780
Tuberculosis (all forms)	39,032	25,483	13,549
Syphilis and its sequelae	8,236	6,179	2,057
Acute poliomyelitis	2,074	1,261	813
Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues	204,651	102,671	101,980
Diabetes mellitus	24,488	9,671	14,817
Major cardiovascular-renal diseases	746,854	420,544	326,310
Pneumonia and influenza	40,042	22,738	17,304
Ulcer of stomach and duodenum	8,020	6,540	1,480
Appendicitis	3,792	2,304	1,488
Hyperplasia of prostate	6,027	6,027	....
Complications of pregnancy, childbirth and the puerperium	2,954	....	2,954
Congenital malformations	18,692	10,353	8,339
Birth injuries	12,320	7,164	5,156
Postnatal asphyxia and atelectasis	12,301	7,521	4,780
Immaturity	24,480	13,802	10,678
All accidents	88,681	61,820	26,861
Suicide	17,125	13,258	3,867
Homicide	8,812	6,686	2,126

Note: Deaths from specified causes do not equal deaths from all causes because of the omission of some categories from the table.

Seventy-Eighth Annual Convention
Florida Medical Association
Hollywood, April 27-30, 1952

Epidemiologic Importance of Man's Transportation of Mosquito Vectors of Malaria

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Mosquitoes, by the hundreds, come to Florida from South of the Border yearly. These potential malaria and other disease-carrying pests come in "on the wing," but fortunately for us they are riding the airliners, and most of them are dead when landed.

Their presence is nothing new, since mosquitoes have probably plagued man throughout his entire existence. Fossil specimens indicate that there were Culex species on earth before man made his appearance here.[1] The intermittent fevers, considered by many to be malaria, are among the oldest recorded diseases.[2] Chinese mythology described three demons, assigning to the first a hammer, to the second a pail of cold water, and to the third a stove. These supposedly represented the headache, the chill, and the fever.[3]

The Greeks and the Romans, during the time of Christ, showed some understanding of the epidemiology of the disease and speculated as to its etiology. Varo (118-29 B.C.) even referred to the little animals that were invisible to the eye, were borne by the air, and would cause disease that one could get rid of only with difficulty. The Hindu Susruta, in the fifth century A.D., attributed the spread of a disease to the mosquito and gave a fair description of malaria.[3,4]

Yet, during the next 1,500 years little knowledge was gained regarding this disease, although it was relatively widespread throughout the civilized world. Hence it is difficult to evaluate the part man's transportation of the malaria vector has played in world history since the fall of ancient Greece to its present attack on modern India. Some think that the welfare of Greece was undermined by it.[1]

The possibility of transporting the malaria vector, as such, was not recognized early.[1] In fact, not until Ross and the Italians performed their classical work did the mosquito control phase get any more attention than was necessary to minimize these insects as a public and personal nuisance. The epidemiologic importance and the public health implications simply had not been appreciated.[5] The earliest recorded instance in which a mosquito vector of malaria was transported by man was an experiment. In 1900, infected mosquitoes were sent from the Roman Campagna to London; two subjects were bitten by these mosquitoes and became ill in "due time" with malaria.[6]

Ross,[2] in retrospect, referred to outbreaks of malaria that occurred in 1866 and 1867. He described the islands of Mauritius (550 miles east of Madagascar) and Reunion, separated by 125 miles of water. He stated that on both islands there was a severe epidemic. Epidemic malaria had been unknown prior to 1865. The outbreaks occurred simultaneously in the two islands. He and others expressed the opinion that these were the result of Anopheles gambiae having been introduced by a boat from Africa or elsewhere one or two years prior to the outbreak.[1,7]

Herms and Gray[5] stated that the problem of transporting mosquitoes has been present for hundreds of years, and the following quotation is indicative of the part transportation could have played. These were the posted regulations regarding steamer traffic on the Nile River in 1903.

> ". . . . 3. The thing to be avoided is returning to Khartoum with mosquitoes on board. If this is done, wells and water collections in the town which have been cleared at trouble and expense are liable to become reinfected. This has happened repeatedly, so that it is very important that steamers should arrive clean and free. It is well to have all bilge water emptied on arrival and all steamers lying up should be inspected and treated in the manner described. Similar precautions are required as regards barges, launches and any vessel on which there is stagnant water. Note — It has been proved that mosquitoes, as a rule, will not stay for any length of time on a steamer if they are prevented from breeding out on board. Consequently, such preventive methods are effective, as has been demonstrated on several occasions; and there is no excuse in most instances, for steamers reaching Khartoum with their bilge water, etc., full of larvae and pupae, and their cabins full of adult mosquitoes."[2]

It was stated that these regulations were put into effect after species of Anopheles were found to be breeding on the boats plying the Nile.

For the same year, 1903, Grubbs,[7] Past Assistant Surgeon, United States Public Health and Marine-Hospital Service, presented interesting data concerning the transportation of mosquitoes by ships. He listed the findings on 82 vessels inspected at the Gulf of Mexico Quarantine Station. Five ships admitted having mosquitoes at port of departure, two getting rid of them when well at sea, and three carrying them for only two days. Four of the five had no further trouble, but the fifth, a schooner, again had an abundant supply when shore was reached and after several days at sea. Nine of the vessels had no mosquitoes on departure (so the captain stated), but had them appear at sea. Grubbs[7] recounted that on one ship he was met by a constant "buzzing" in the forecastle, and all who entered were attacked by many mosquitoes.

All of this was happening in the twentieth century and after years of a form of quarantine practice. Quarantine was being applied during Biblical times, and Venice was operating a Maritime Quarantine Station in 1403, almost a century before America was discovered. Our present quarantine law was enacted in 1893 and extended to cover aircraft in 1926.

In 1904, 2 male and 129 female mosquitoes of the Anopheles albimanus species were taken at Key West, Florida.[8] MacDonald, the investigator, thought all of these to be the progeny of a single female, possibly transported by a vessel from Vera Cruz, Mexico. Further, he believed that he completely exterminated the breed, thus preventing a successful invasion by the West Indies' chief malaria vector. Single specimens, however, have been taken at intervals since that time.[8,9,10]

The first commercial airplane flight to the United States from a port outside the continent was made in 1927 from Havana, Cuba to Key West, Florida.[11] It was realized early that air transportation presented an entomologic threat of public health significance. There are approximately 290 recognized species and varieties of Anopheles alone, not more than 12 of these occurring in the United States and Canada;[9] 62 others belong to our Southern neighbors and 22 to Europe and North Africa. South Africa has 85 species with 109 listed in Asia, the Philippines, and the Australian region. Fifty-four of the 290 total are regarded as important vectors somewhere within their range. Only 3 of these are found in the United States at the present time.

The epidemiologic possibilities[5] of man's transporting of the mosquito vectors are:

1. The introduction of a new and more efficient vector into an infected area.
2. The introduction of an infected vector into an area where vectors do not exist.
3. The introduction of infected vectors into an area where vectors, free of disease, are in abundance.
4. Increased expenses to states and communities because of the population's high susceptibility,[12] and radical and costly alterations in anti-mosquito measures necessitated by the habits of the newly introduced mosquitoes.

Soper and Wilson[13] in 1943 gave an excellent account of the establishment of the A. gambiae in Natal, Brazil. None of this species were found in this area in 1928 during a rather complete survey in search of Aedes aegypti. Two thousand larvae were collected in Natal in March 1930. The A. gambiae is believed to have crossed the Atlantic late in 1929 or early in 1930 on one of the fast destroyers.[11] The boats made the trip from Africa to Brazil in less than 100 hours. It is thought to have made the trip in the adult form since all the water containers were closed and no larvae on ships were ever found. These ships anchored within 1 kilometer of the shore, which is within easy flight range of this native African vector. Three planes could have been involved, although larvae or adult mosquitoes of this species were not recovered at or near the airport.

This chance introduction cost thousands of lives and an inestimable amount of time and money spent in eradication.[13] If this species has been eradicated, as it now appears, it is the first such case on record and will have a direct influence on the mapping of future fights on malaria.

During the late war, mosquitoes were transported by plane and military convoy into areas not previously inhabited by their species.[3] Cargo vessels from New Guinea and the Philippines, carrying automobile and truck tires, arrived at Los Angeles with live adult mosquitoes in the hold.[14] It is obvious that mosquitoes can easily gain entrance to a new area, and even harmless ones in their native habitat might possibly become vectors of disease in their new environment. The fact remains, however, that malaria-free areas still exist, even though topography and climate appear

ideal and chance introduction is an ever present possibility.[15]

During an eight year period from 1940 through 1947, more than 12,000 mosquitoes were found in aircraft entering the United States. Many of these were collected at Miami's International Airport, and only a small percentage were living when collected.[11] During 1948, 1949, and 1950, only 601 mosquitoes were taken at Miami, and of this total, 445 were dead.[16] So long as known methods of environmental sanitation and the proper spraying of transporting vehicles are utilized effectively, and with constant vigilance, there will be little danger from such importations.[17]

The Foreign Quarantine Service of the United States Public Health Service maintains a year-round service where the hazard of importation and possible implantation of disease-carrying arthropods exists.[11] This service is aware of no record of establishment of a species of mosquitoes or other arthropod vector in the United States or its territories as a result of importation by aircraft.

Florida still presents an ideal habitat for mosquitoes, not only for the malaria vector, but the vectors of yellow fever, dengue, encephalitis, and filariasis as well. The yearly expense of preventing successful entry is small when compared with a single campaign that is necessary when a new species is imported.

Summary

The literature on man's transportation of the mosquito vector of malaria has been reviewed.

One of three criteria must be fulfiled if this transportation is to be considered epidemiologically important:

1. Introduction of a new vector (infected or noninfected) into an area.
2. Introduction of a more efficient vector to an area already infested with infected mosquitoes.
3. Introduction of an infected vector into an area where vectors, free of disease, are in abundance.

The extent played by man's transportation has not been established. The geographic distribution of the mosquito vector of malaria at the time man began his travels is not known. Priority has not been established in many areas as the epidemiologic importance and Public Health implications of the mosquito were not appreciated until near the turn of the twentieth century.

The literature indicates that the mosquito was allowed to travel rather freely on the ocean-going vessels in the early days. Indications are that they have utilized practically every mode of transportation of modern times; yet the actual geographic distribution of the Anopheles mosquito has changed but little during the past fifty years.

The possible eradication of the A. albimanus in Key West, Florida and the A. gambiae in Brazil was reported.

The epidemic in Brazil was reported as having resulted from man's importation by boat of a more efficient vector while the explosive outbreaks in Mauritius and Reunion probably resulted from the importation by boat of an infected vector.

Numerous importations by planes were listed. No evidence was presented, however, that would indicate the establishment of a new species as a result.

Though importation and successful implantation are more potential than acute, it is prerequisite that man be continually on guard against the possibility of transporting Anopheles into such areas as New Caledonia and Hawaii. Neither does he want to import the Anopheles darlingi to Africa, the salt water Anopheles sundaicus to the Philippines, nor A. gambiae again to the new world.

Importation in the early instances may be charged to ignorance, but the literature cited indicates that man now has the knowledge and equipment to rid the transporting vehicle of disease-bearing vectors. Henceforth, it can, perhaps, be charged to neglect.

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A Technic for Early Postoperative Care of "Wet Colostomies"

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With the advent of the pelvic evisceration for carcinoma of the cervix advocated by Alexander Brunschwig, the "wet colostomy" has presented an increasing problem. The late care of the "wet colostomy" has been satisfactorily handled by the use of the Rutzen bag, which is sealed to the skin by a special cement. The early postoperative care has been particularly difficult because of the constant urinary and fecal contamination of the fresh wound.

The following procedure has been used to facilitate the early postoperative care of patients subjected to this operation: Catheters large enough to fit snugly are placed in the ureters after the ureters are separated from the bladder and fastened with a circular tie close to the distal end. The ureterocolostomies are performed in the usual manner with the distal ends of the catheters placed within the large bowel. After the colostomy has been completed, the bowel is opened, and the catheters are "fished" out and securely anchored to the skin dressing so that no pull can be exerted on the ureters. Each individual catheter is connected to a drainage bottle. Although only rubber catheters have been used up to the present time, these have been left in place for over two weeks without difficulty. The use of less irritating substances like polyethylene tubing may permit the retention of these catheters for longer periods of time. The catheters are simply pulled out in order to remove them.

The suggested method of handling the ureters in "wet colostomies" offers the following advantages:

1. It permits the wound to stay dry until healing of the wound has occurred, and it is then possible to use a Rutzen bag.

2. The ureters are kept open, and adequate drainage to the kidneys is assured.

3. Reabsorption of waste products in the large bowel is prevented in the early postoperative period.

4. It is possible to check urinary function from the individual kidneys.

5. Ascending infections in the ureters are minimized until the patient convalesces from the operation.

Summary

A technic for the handling of ureters in "wet colostomies" is reported.

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From the Gynecologic Service of the Duval Medical Center.

From Our President

American Medical Education Foundation

There are probably very few members of the medical profession who are not aware of the financial plight of the medical schools of this country. Inflation, with its accompanying increased operating costs and decreased revenues, is the obvious cause.

As always, the Federal Government has the answer, subsidization. A recent ruling of the United States Supreme Court holds that what the government subsidizes, it also controls. Should the medical educational system of this country fall under Federal control, a great wedge toward socializing the medical facilities would have been established. It is hard to believe that the Federal Government would be any more successful in its operation of the medical schools than in its other activities. A deterioration in the quality of the medical profession would be inevitable.

The chaotic condition of medical education in this country, in the middle of the last century, was largely responsible for the founding of the American Medical Association. Its interest in medical education was the motivating factor of this organization for the first fifty years of its existence, and has resulted in the highest standard of training in this field the world has ever known. The success of this endeavor is reflected in the health of our citizens. This is the healthiest large nation in the world.

The American Medical Association has remained keenly interested in medical education and has proposed a two point program for meeting the present crisis. First, the American Medical Association proposes one time Federal grants for renovation of existing facilities and construction of new physical plants.

These funds are to be administered locally and would be relatively free of the danger of Federal control. Such a grant will solve the largest financial difficulty.

Second, the American Medical Association proposes the increased contributions from private sources for operating expenses.

The American Medical Association organized in December, 1950, the American Medical Education Foundation to carry out this program. This Foundation has requested of each of the physicians of this country, $100. Such a contribution would annually yield approximately $18,000,000. In addition to aiding in operating the schools, it is hoped that the response on the part of the profession will stimulate lay contributions. Under our present economic condition and the present tax program, philanthropic endeavors must of necessity have a broader base than previously, i.e., many small contributors must participate in contrast to the single philanthropist of the past.

The monies collected by the American Medical Education Foundation will be distributed to the medical schools to be used as needed. The American Medical Association has assumed the cost of operating the Foundation, so that all money collected would be used for the purpose to which it was donated. The contributor may designate the school to which his contribution is to be given, if he so desires. The United States Commissioner of Internal Revenue has ruled that these contributions are exempt from taxation.

It is understandable that many doctors in Florida will be unable to donate $100, but each can give something. The Medical Education and Hospital Committee of the Florida Medical Association has the special assignment to urge gifts. Each component County Medical Society has a committee with a similar purpose.

If you are wondering why you should contribute, remember that someone else paid for your medical education; your tuition and fess were entirely inadequate. If you attended a tax supported institution, the tax payers of that State assisted you. If you were educated in one of the endowed schools, the supporting foundation supplied the deficit.

Florida can not look with pride on its medical educational facilities, but with your help it can lead in the support of the American Medical Education Foundation.

David R. Murphy Jr

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Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., Sec'y., 1950.....*St. Augustine*

VOLUME XXXVIII
NUMBER 8

The Journal of the Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION

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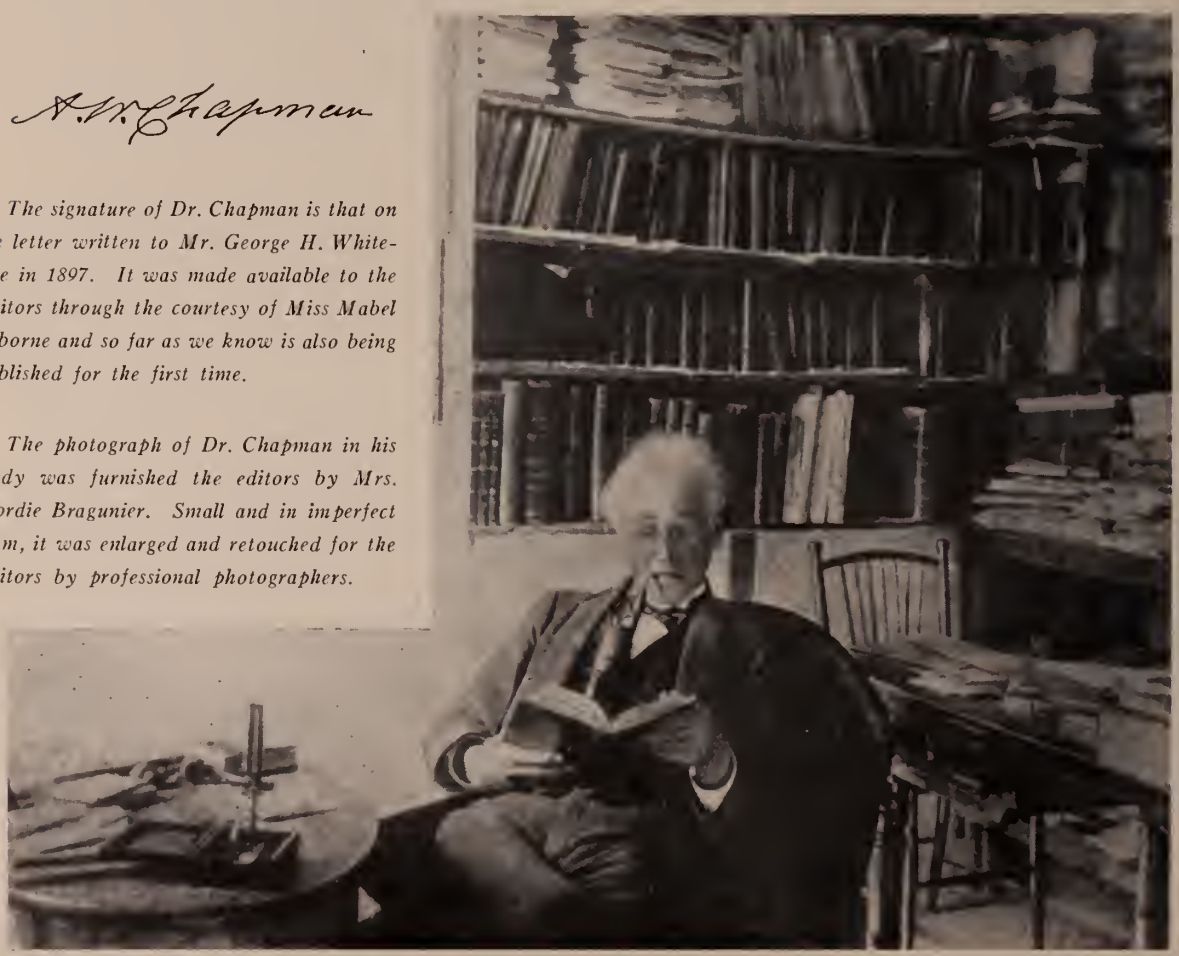
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The signature of Dr. Chapman is that on the letter written to Mr. George H. Whiteside in 1897. It was made available to the Editors through the courtesy of Miss Mabel Osborne and so far as we know is also being published for the first time.

The photograph of Dr. Chapman in his study was furnished the editors by Mrs. Mordie Bragunier. Small and in imperfect form, it was enlarged and retouched for the Editors by professional photographers.

Famous Florida Physicians: Gorrie and Chapman

In the thriving little seaport of Apalachicola, the third largest cotton market on the Gulf Coast, a young physician named John Gorrie arrived in 1833. About the same time, another young physician settled in West Florida. He chose Quincy for his home, later moved to Marianna and then in early January 1846 he, too, settled in Florida's principal commercial town, Apalachicola. The name of this second young physician was Alvan Wentworth Chapman. Around his remarkable life story notable events in Florida revolved for more than half a century.

Born at Southampton, Mass., on Sept. 28, 1809, Dr. Chapman died at his home in Apalachicola on April 6, 1899, in his ninetieth year. The son of Paul and Ruth Pomeroy Chapman, he entered Amherst College at the age of 17, graduating with honor four years later. From 1831 to 1833 he was the tutor of a family on Whitemarsh Island, near Savannah, Ga., and in 1833 he was elected principal of the academy at Washington, Ga. It was there that he began the study of medicine, and upon moving to Florida in the winter of 1834-1835, he began the practice of medicine, which he continued for more than half a century.

Dr. Chapman had received no formal training in botany, but his interest therein began before he left New England. Soon after his arrival in Florida, he began sending specimens of Southern plants to Dr. John Torrey, distinguished New York botanist, and his famous pupil, Dr. Asa Gray. His first letter to Dr. Torrey was dated Gadsden County, Jan. 12, 1835. In 1838 the genus Chapmania was named in his honor. The semitropical and tropical vegetation of Florida so fired Dr. Chapman's mind that he became its pioneer investigator. In 1843, his quest led him as far south as Key West. He became the foremost authority on "Flora of the Southern United States." His book bearing that title was published in 1860 and republished in two later editions. For nearly fifty years it was the only manual of the flowering plants of the Southeastern states.

Dr. Chapman was a handsome man. He was about 6 feet tall, and his hair was of that fine texture which is likened to snow. His eyes were clear and blue. He usually wore dark blue suits, was dignified in his movements and walked slowly with head slightly forward, a habit acquired from searching the ground for flowers. He was deaf, but his sight was remarkably good with one exception. He was color-blind. After Dr. Gray had visited him, Dr. Chapman wrote:

> I had . . . found a new Rhododendron in bloom. . . . Fortunately he came early enough to catch the pretty witch in bloom. . . . It always looked white to me but Gray said it "blushed pink." . . . "You are right," he said. "I never saw this species. I congratulate you on Rhododendron Chapmanii."

Dr. Chapman could not detect the color red in any of its shades. Blue was clear and natural, but a red rose to him looked dull brown.



John Gorrie

This picture of Dr. Gorrie is a reproduction of a portrait by Charles Foster.
The signature of Dr. Gorrie, executed in 1837, is being published perhaps for the first time.

In 1839, Dr. Chapman married Mrs. Mary Ann Hancock of New Bern, N. C. During the War Between the States she went to her former home in Marianna. He is quoted as saying:

> I was a Union man . . . and right there my wife and I disagreed. . . . We agreed to part. . . .I never saw her during those . . . stirring years [of the war].

Dr. Gorrie having died in 1855, Dr. Chapman was the only physician in Apalachicola during the war. That fact may have saved his life, for his

services were in demand even by his enemies. He said that many times he would not have given sixpence for his life.

After the war he began to devote more time to botany and less to medicine. Later he humorously said:

> . . . there is a lot of pother in this doctoring; and I find that my deafness is not entirely detrimental, since if I can't hear people's groans they won't send for me. My flowers are far more satisfactory. . . .

In 1886, the University of North Carolina conferred the LL.D degree upon him.

In February 1897, about two years before his death, Dr. Chapman wrote a letter to Mr. George H. Whiteside in reply to his request that Dr. Chapman give him personal information about Dr. Gorrie. Mr. Whiteside's first article published in "Ice and Refrigeration," in May 1897, and subsequent articles by him have been quoted many times.

Dr. Gorrie's life has become much better known than that of Dr. Chapman. Nevertheless, although Dr. Gorrie was the first to produce artificial ice and the father of air conditioning, not until recently, could even a short biography of Dr. Gorrie be found in the Encyclopaedia Britannica. To Mr. Whiteside; to the Southern Ice Exchange, which erected a monument to Dr. Gorrie in Apalachicola in 1900; to Col. G. N. Saussy, who first advocated the placing of Dr. Gorrie's statue (1907) in the national Hall of Fame; to Drs. Edward Jelks and H. Marshall Taylor of Jacksonville, who published articles on Dr. Gorrie in 1931 and 1935; to Miss Mabel Osborne of Apalachicola and Mrs. Laural Hobbes of Jacksonville, who have unceasingly worked for better recognition of Dr. Gorrie; to Ruth Eugene Mier, who in her Master of Arts thesis at Stetson University in 1938 corrected several errors and added information concerning Dr. Gorrie's life, we owe much.

Quite a bit of the information concerning Dr. Gorrie's life which is available to us today is based on Dr. Chapman's reminiscences. The mystery surrounding Dr. Gorrie's birth and early years in South Carolina perhaps will never be entirely cleared. The famous Mansion House story, which is perhaps the best known and most dramatic incident of Dr. Gorrie's life, probably did not occur in 1850, but perhaps in 1849. The Editors of The Journal have incontrovertible evidence that the large ice cubes were first made in a machine manufactured for Dr. Gorrie, not in New Orleans or Pensacola, but in Cincinnati, Ohio. The time was the fall of 1848. This information will be enlarged upon later, but is given now to show that much more study and research are needed to develop properly the true life story of Drs. Gorrie and Chapman.

Dr. Chapman's integrity and reliability as a historian were of the highest order, but errors in memory with regard to dates and important particulars have necessarily occurred.

Toward the end of his life, Dr. Chapman remained vigorous in both mind and body. Like so many great men, he had a simple creed. It seems to be summed up by the quotation from Coleridge which he adopted as his own:

> He prayeth best who loveth best
> All things both great and small;
> For the dear God who loveth us,
> He made and loveth all.

Within a week of his death, Dr. Chapman walked two or three miles to gather the blossoms of a rare species of the ash tree. On April 6, 1899 he was seized with a heart attack, probably coronary occlusion, the pain of which did not respond to treatment as had previous attacks of pain. In about an hour he died. On his mantel were flowers which had recently arrived at his home, Viburnum desifilorum, locally known as Chapman's honeysuckle.

Those who thought that Dr. Chapman was a stern and haughty man were mistaken. His interest in flowers and plants, their growth, characteristics and beauty, gave him no time for pettiness or small thoughts. He gave himself to his professions and a few friends. To people in general his deafness served as a barrier which afforded him the isolation he loved and enabled him to devote himself assiduously to botany and medicine.

Largest Medical Defense Meeting Held

The success of the Medical Civil Defense Conference held in Chicago in mid-November was declared by a spokesman for its sponsors to be "a real inspiration to all of us in exerting a greater effort for the big job ahead." The attendance of 250 was the largest so far for a medical meeting of this kind. The meeting was sponsored by the American Medical Association, the American Hospital Association and the Association of State and Territorial Health Officers.

Noteworthy is a resolution, unanimously adopted, calling for all medical personnel to be "assigned to their proper places in the local civil defense organization; their assignment to be the responsibility of the legally authorized civil defense officers according to the laws in the various states, and

only after full consultation with the local, state and or national professional health organizations which exist in the various fields."

The resolution provided further that "the professional and tactical organization and training of individuals and units will be the prime responsibility of legally authorized civil defense officers, again, only after full consultation with local, state and or national professional health organizations in these fields."

The many speakers, among them Millard F. Caldwell, administrator, Federal Civil Defense Administration, stressed the necessity of coordination between health and welfare planning in developing a well rounded program of disaster relief. It was pointed out that genuine nationwide cooperation between the health officer, the hospital and the medical and allied health personnel—of all categories—is essential to the success of the civil defense movement. One speaker particularly emphasized that the necessity for mobile support, to be fully met, must depend upon health personnel in the remote areas, not in the target areas.

"If there was one central theme," commented Dr. James C. Sargent of Milwaukee, chairman of the A. M. A. Council on National Emergency Medical Service which sparked the meeting, "it seemed to be that now since the preliminary phases of planning, financing and procedure have passed, it is high time to make a positive and concerted effort at recruitment of the hundreds of thousands of American citizens necessary to carry out this gigantic program."

The General Practitioner and Industrial Medical Practice

Increasingly during recent years, responsibility for industrial medical service, particularly illnesses and injuries related to employment, has been accepted by the general practitioner. It has been estimated that he renders as high as 85 to 90 per cent of industrial health services. The report of a survey made by the American Academy of General Practice in May 1950 is therefore of particular interest, for its purpose was to determine the distribution and type of practice of its members.

This survey revealed that 95 per cent of the membership cared for industrial cases. In 1948, such cases averaged 234 per member. Approximately 20 per cent of the membership engages in full time industrial practice.

In view of these significant findings, a joint committee of the Academy of General Practice and the Council on Industrial Health of the American Medical Association, meeting with representatives of the American Medical Association Section on General Practice, agreed upon the desirability of formulating a joint program for the education of general practitioners in the fundamentals of industrial medical practice. The program and curriculum are to be implemented on a national, state and local level through joint cooperative effort of the participating groups.

While the need for development of an industrial health education program geared to the requirements of the general practitioner is not new, it nevertheless takes on added significance in the present national emergency. To meet the health needs of a rapidly expanded work force in war industries during World War II, it was necessary to draw heavily on the services of the general practitioner. Currently, the national defense program makes it necessary again to look to the general practitioner in planning for the health needs of the workers in essential industry. He is privileged to make an important contribution toward the success of the national defense program which depends on effective industrial production. No doubt he will welcome a properly coordinated national program of education designed to orient him for the full discharge of this task.

British Surgeon Reviews Health Plan

Speaking in Chicago recently, Dr. A. Lawrence Abel, president of the London area of the British Medical Association, described himself as "not a politician but merely a humble member of the medical profession working hard at practical surgery in the heart of London." He told the annual convention of the International College of Surgeons that the cost of the National Health Service in England has far exceeded all estimates made before and during the time it took effect four years ago.

"The exchequer has at last realized," said this distinguished representative of the British Medical Association, "that my country cannot afford to make available the unbridled use of such an essential service. Whereas last year the health service cost nearly one billion, five hundred million dollars, they have now imposed an arbitrary ceiling of under one billion, two hundred million dollars . . . and a few weeks ago ordered that 50 per cent

of the cost of dentures and spectacles should be paid for by the patient."

Despite the huge cost, Dr. Abel made the surprising statement that out of the weekly contribution to national insurance the family doctor receives less than three cents. He remarked that in England twenty cigarettes cost 49 cents, each cigarette costing 2½ cents, and then observed, "The family doctor, therefore, out of the contribution receives the equivalent of approximately one cigarette a week!"

So far as he could recall, not a single promise made by the politicians to both doctors and patients has been kept. He painted a depressing picture as he recited the pitfalls of this vicious system. They are the same pitfalls strewn in the path of the medical profession in this country by vote-conscious politicians in their efforts to enact some form of compulsory health insurance. As in England, they promise the sky, knowing only too well from British experience that they cannot deliver.

Graduate Medical Education

The Department of Medicine of the Graduate School of the University of Florida through the Committee on Medical Postgraduate Course of the Florida Medical Association announces its schedule of graduate courses offered for the first six months of 1952.

The Midwinter Seminar in Ophthalmology and Otolaryngology was held the week of January 14-19 in Miami Beach. This was the sixth annual presentation of this specialized course. Each session has been well attended and has offered the best in this field.

The Seminar on Diabetes, lasting two days, will be presented the latter part of March or the first part of April in West Palm Beach. The date will be announced in the March issue of The Journal, and notices will be sent to the various county societies throughout the state as soon as the exact date and speakers are ascertained.

On June 19-21, a Seminar on Diagnosis will be held at the George Washington Hotel in Jacksonville. The tentative outline for this course is a series of six lectures each on Thursday and Friday. Dr. Lewis M. Hurxthal will give the lectures on Clinical Diagnosis, Dr. Hugh F. Hare those on Roentgenology, and Dr. William Meissner those on Laboratory and Pathological Diagnosis. All three are from the Lahey Clinic, Boston. On Saturday Dr. Hurxthal will give two lectures summing up the material presented on the previous two days and with the other two lecturers will hold a special question and answer period and round table discussion. These lecturers are nationally known, and we are most fortunate to have the opportunity to hear them. The lectures will be well coordinated while they are being prepared. This Seminar is designed primarily for diagnosticians, internists and those physicians desiring to improve their diagnostic acumen.

The Twentieth Annual Graduate Short Course will be held as usual the last week in June, 23-28 inclusive. There will be several changes in the instructors this year, some of whom have already been secured. The Faculty will be announced later. Again this year the extra lectures coming the first three days will be devoted to Diseases of the Chest. The speaker will be outstanding in this field.

* * * *

The division chairmen of the Department of Medicine agreed unanimously to offer one day sessions in various cities throughout the state at the request of the county societies. Suggestions have been received, and plans are being made to present this graduate work to the physicians.

Second Annual Medical Seminar Mount Sinai Hospital

"Recent Advances in Diagnosis and Treatment" has been selected as the topic for a three day intensive postgraduate course at the Second Annual Medical Seminar of the Mount Sinai Hospital, Miami Beach, May 22-24, 1952.

Included among outstanding physicians from throughout the nation who will participate in the seminar are: Dr. James H. Means, Professor of Clinical Medicine at Harvard Medical School; Dr. William Dameshek, Professor of Clinical Medicine at Tufts College Medical School, Boston; Dr. D. M. Bergenstal and Dr. Joseph B. Kirsner, University of Chicago, The School of Medicine; Dr. Rachmiel Levine, Director of the Department of Metabolic and Endocrine Research at Michael Reese Hospital, Chicago; Dr. Daniel C. Darrow, Professor of Pediatrics, Yale University School of Medicine; and Dr. Robert Elman of the Department of Surgery at the Washington Universty School of Medicine, St. Louis.

Chairman of the Seminar Committee is Dr. Paul N. Unger, assisted by Dr. David A. Nathan, Dr. S. Charles Werblow, and Dr. Richard M. Fleming. Assisting committee chairmen are: Dr.

Louis Lemberg, Dr. Jandon Schwarz, Dr. Samuel B. Kleinman, Dr. Leo M. Levin, and Dr. Paul Plotkin.

Registration fee is $20. An additional $7.50 will be necessary for those planning to attend the banquet. Interns and residents will not be required to pay a registration fee.

Highlights of Los Angeles A. M. A. Clinical Session

Surpassing numerically all expectations, the success which attended the Fifth Clinical Session of the American Medical Association at Los Angeles last December reflects the best tradition of the Far West and sets a high goal for future host cities to attain. Denver, coming next with this year's meeting on December 2-5, faces a real challenge to meet the Los Angeles record, as does St. Louis in '53. Then comes Miami in '54, and every member of the Florida Medical Association will anticipate with pleasure the opportunity to help make the Eighth Clinical Session here in Florida altogether as outstanding as any of the preceding meetings.

At the Los Angeles meeting there were more than twice as many registrations as at the Cleveland meeting in 1950. Physicians registering numbered 4,419 and guests 4,656, a total of 9,075. This was by far the largest clinical meeting yet held. The two day Public Relations Conference preceding the clinical session likewise attracted a record attendance, totaling 450. The 39 newspaper and magazine writers covering the clinical session comprised the largest group ever assigned for this purpose.

Some 7,000 persons crowded into the auditorium of the Shrine Convention Hall for the nonpartisan public forum appearance which this great nonpartisan professional organization afforded Senators Robert A. Taft and Harry F. Byrd, who warned against the dangers of "creeping socialism." About 2,000 others could not be admitted because of lack of space.

"The next year," said President John W. Cline of San Francisco in his address to the House of Delegates, "will be one of important decision. . . . If we are to protect our heritage of freedom . . . this decision must be correct. . . . Should this country continue on the road which leads to socialism, those things which we cherish will be irrevocably lost."

Making a surprise appearance before the House of Delegates, Donald R. Wilson of Clarksburg, W. Va., National Commander of the American Legion, declared that "three million members of the Legion stand shoulder to shoulder with you, as doctors, in your battle to overcome the encroaching forces of socialized medicine."

Said Dr. Elmer L. Henderson of Louisville in his report to the House as chairman of the A. M. A. Campaign Coordinating Committee, "The election year ahead is perhaps the most critical year of the medical profession's existence as a free society, dedicated to the health of the nation, unhampered by politics."

Still in active practice after half a century of service, Dr. Albert C. Yoder of Goshen, Ind., at the age of 84 became the choice for the A. M. A. general practitioner of the year. Reminiscing about the "good old days," Dr. Yoder said, "Back in 1903, I had my first appendectomy, on a college student . . . on a kitchen table . . . patient made a nice recovery . . . later went on to medical school. . . ." It was this same patient who suggested Dr. Yoder's name for nomination as Indiana's family doctor, which proposal led eventually to his selection for the fifth annual general practitioner's award at the Los Angeles meeting.

Report of Delegates to A. M. A. Atlantic City, June 11-15, 1951

The one hundredth annual session of the American Medical Association was held in Atlantic City, N. J., June 11-15, 1951. This was the first year the Florida Medical Association had three representatives in the House of Delegates. The ratio is based on the number of active members of our association who are also members of the A. M. A.

The House of Delegates was called to order by the Speaker, Dr. F. F. Borzell of Philadelphia at 10 a. m. June 11. In his address he stated in part that, "The passing years have not eased our tasks or reduced our responsibilities. On the contrary, because our predecessors have built so well, we find ourselves in the forefront of a struggle for the preservation of the very fundamentals of those principles which make life worth living. There have been times when clouds were dark and it looked as though our structure would crumble, but I say to you in all sincerity that the American Medical Association was never stronger than it is today."

The retiring president, Dr. Elmer L. Henderson, Louisville, Ky., delivered a splendid address covering many details on "Objectives for the Future." He paid high tribute to Whitaker and Baxter for their outstanding work in behalf of freedom in medical practice through the National Education Campaign.

The Chairman of the Board of Trustees, Dr. Louis Bauer, Hempstead, N. Y., made a detailed report to the House. Among the many items mentioned were hospital standardization by a joint committee of the American Medical Association, the American College of Surgeons, the American College of Physicians and the American Hospital Association. Dr. Bauer through his many years of hard work in the Association knows all the answers. He was honored as the president-elect.

The local committee on arrangements for the clinical session in Houston, Texas, recommended that the meeting be canceled because of the unavailability of suitable facilities. Therefore, the Board of Trustees accepted an invitation to meet in Los Angeles, Dec. 4-7, 1951. Through the efforts of your two senior delegates the Clinical Session will be in Miami in 1954.

Many and various resolutions were presented to the House which were referred to the reference committees for hearings and recommendations. The entire proceedings of the House of Delegates were published in the A. M. A. Journals of June 30 and July 7, 1951. You are referred to those two issues for detailed information. Dr. R. S. Kneeshaw of California presented a resolution that should be of interest to all of us. It requested the Board of Trustees to establish a system of preceptorship for the instruction of medical students in the art and economics of the practice of medicine, such a system to be organized within the framework of the Student American Medical Association and with the aid and approval of the local county medical society.

The House voted Dr. Allen O. Whipple, New York City, the distinguished Service Award for 1951.

Dr. John W. Cline, San Francisco, was installed as president. He is recognized as a great leader with ability and sound judgment. In his address he pointed out that medical progress in the last half century has added twenty years to man's life span, reduced maternal mortality to the lowest in the world and cut infant deaths thirty-eight per cent in the last decade.

The registration of F. M. A. members at the meeting in Atlantic City was 136. Your two senior delegates to the American Medical Association are doing a splendid job in representing Florida. They are most competent and have been recognized in being given important appointments. Dr. Homer L. Pearson, Jr., Miami, has been a member of the Judicial Council for some time while Dr. Louis M. Orr, II, Orlando, is chairman of the Reference Committee on Hygiene and Public Health. Ability with seniority means a great deal in the House of Delegates. If these two gentlemen are continued as your delegates, it is believed that Florida will eventually be represented on the Board of Trustees.

It was my honor to have served as one of your delegates back from 1936 to 1940. During that time I served on several reference committees. I am grateful for the honor of again representing Florida with Doctor Pearson and Doctor Orr.

Respectfully submitted,
Herbert L. Bryans, M.D.

Report of Delegates to A. M. A. Los Angeles, Dec. 4-7, 1951

The Fifth Annual Clinical Session and the mid-year meeting of the House of Delegates of the American Medical Association was held in Los Angeles, Dec. 4-7, 1951.

The House was called to order at 10:00 a.m., Tuesday, December 4, by the Speaker, Dr. F. F. Borzell.

We were addressed by the President, John W. Cline, who spoke forcefully about our political obligations and the importance of holding the advanced positions we have gained. He said, "We must never let it be necessary for American Medicine to be on the defense again."

Past President, Elmer Henderson, Chairman of the National Educational Campaign Committee, made a fine report on the accomplishments of the committee to date. He also announced that after Jan. 1, 1952 Whitaker and Baxter would no longer be employed full time by the American Medical Association, but would continue on part time. It is the feeling that the Department of Public Relations of the Association now has developed to the degree that it can, with the aid of Whitaker and Baxter and the doctors of America, do a good public relations job in the future.

Dr. Henderson also reported on the American

Medical Education Foundation as follows: The response of physicians to the cause was lamentable in that so few had contributed so little. If we cannot support our own program how can we expect others to do so? The Board of Trustees donated another $500,000 to the Foundation on behalf of the American Medical Association. The doctors of America are called upon to contribute $100 each annually to medical education.

Many committee reports were made and a number of resolutions presented, the contents of which may be found in the December 22 issue of the A. M. A. Journal. The Constitution and By-laws of the Association are being changed, subject to final action at the June 1952 session, so that there will be no more fellowships. Fellowship dues for 1952 have been abolished. A. M. A. membership dues for 1952 are $25 which include the Journal.

The Hess report of two years ago was referred back to the House revised and adopted. This report had to do with the practice of medicine by hospitals and it contained certain recommendations which were deemed unwise.

On Wednesday evening at seven o'clock addresses to the House by Senator Robert A. Taft and Senator Harry F. Byrd were heard and approved. These addresses were broadcast over coast to coast hookup and were forceful in denouncing the trend of our Government to socialism in general, and denouncing socialism in medicine in particular. The December 15 issue of the A. M. A. Journal carries these addresses in full.

The next meeting of the American Medical Association will be in Chicago, June 9-13, 1952.

The Senior Delegate served this House of Delegates as Chairman of the Medical Affairs Reference Committee. Both Delegates attended all sessions.

Respectfully submitted,
Homer L. Pearson, Jr., M.D.
Louis M. Orr, II, M.D.

RESERVE THESE DATES

APRIL 27, 28, 29, 30, 1952

FOR THE CONVENTION IN

HOLLYWOOD

YOUR BLUE SHIELD

Blue Shield Questionnaire

By this time all licensed physicians in the State should have received a questionnaire from the Florida Blue Shield Plan and their cooperation is asked in completing this questionnaire and returning it to the Plan as soon as possible.

The questionnaire was developed to enable the Plan to get to know the physicians a little better and to enable the physicians to express their feelings about participating more actively in the Plan.

In reading through the questionnaire one will note that the first part of it is devoted to pertinent information about the physician's specific practice, which information is most helpful in the administration of the Blue Shield Plan. The physician is then asked about his knowledge of Plan organization and policies and whether or not he would be interested in serving on a Public Relations Committee for Blue Shield in his County Medical Society. The function of such a Public Relations Committee would be to keep the society posted on policies and progress of Blue Shield and to serve as liaison between the medical society and the Plan. The questions which follow pertain to the physician's office staff and their knowledge of Blue Shield reports and procedures.

Blue Shield is constantly striving to determine ways and means of better serving the participating physicians and it is believed that the physicians themselves can help the Plan develop a worthwhile program of physicians' relations by completing the questionnaire and returning it to the Plan promptly.

STATE BOARD OF HEALTH

Creeping Eruption Survey

In an effort to estimate the extent of the creeping eruption (larva migrans) problem in Florida and to determine the various types of treatment recommended by practicing physicians, a post card survey was conducted by the Florida State Board of Health.

During the month of August 1951, post cards were sent to 2,600 physicians in Florida. These physicians were asked to report the number of cases of creeping eruption which they had treated

within the last six months and to give their recommendations as to therapy. There were 1,186 cards returned, representing 45.6 per cent of the number sent out. Five hundred and sixty-two physicians reported no cases treated, and 624 physicians reported a total of 7,928 cases.

Cases of creeping eruption were reported from all counties in Florida with the exception of Flagler, Gilchrist, Glades, Liberty, Santa Rosa, Union and Wakulla. Thirty-seven of the physicians gave their choice of therapy. The three drugs used most often were hetrazan, ethyl chloride, and fuadin. These were given either alone or in combination with other drugs.

Table 1 presents a breakdown showing the types of treatment used by the physicians of the state, the number of physicians using the treatment indicated, and the percentage of the thirty-seven physicians who indicated their choice of therapy.

Table 1. — Analysis of Types of Treatment

Treatment	Physicians Reporting	Per Cent
Hetrazan	7	18.9
Hetrazan and ethyl chloride	4	10.8
Ethyl chloride	9	24.3
Ethyl chloride and local application of ointments	3	8.1
Fuadin	4	10.8
Fuadin and ethyl chloride	3	8.1
Worm treatment (?)	1	2.7
Bichloracetic acid	1	2.7
Ammoniated mercury, fatty acid ointments, and roentgen rays	1	2.7
Potassium permanganate followed by pragmatar	1	2.7
Phenol and 5 per cent salicylic acid in collodion	1	2.7
Libradol (contains nicotine)	1	2.7
Roentgen rays	1	2.7

Studies have been made as to the number of cats and dogs that have the parasites Ancylostoma braziliense and Ancylostoma caninum. A report made by A. W. Donaldson, Sc.D., J. H. Steele, D.V.M., and James E. Scatterday, D.V.M.,* showed that in Florida, in 1950, out of 495 dogs on which a postmortem examination was performed, 219 (44.2 per cent) were infected with A. braziliense, and 426 (86.1 per cent) harbored either A. braziliense or A. caninum or both. Of 26 cats examined, seven were positive for A. braziliense and 22 for one or the other or both species of the hookworm.

This same investigation showed that control measures similar to those against the human hookworms are applicable. In addition, the application of chemical agents such as calcium cyanamide or sodium borate to the soil to kill free-living stages offers some promise of success; however, these findings are not too practical for the control of this disease at the present time.

*From the "Proceedings Book," American Veterinary Medical Association, Eighty-seventh Annual Meeting, Miami Beach, Aug. 21-24, 1950, pp. 83-88.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Harold Carron of Tampa announce the birth of a son on December 8.

Dr. and Mrs. Richard M. Fleming of Miami announce the birth of a daughter, Susan Marion, on December 11.

Dr. and Mrs. Wray D. Storey of Tampa announce the birth of a daughter on December 22.

Dr. and Mrs. Oliver F. Deen, Jr., of Tampa announce the birth of a daughter.

Dr. and Mrs. Joseph J. Lowenthal of Jacksonville announce the birth of twin daughters, Jan A. and Janet B., on January 12.

Dr. and Mrs. William A. Van Nortwick of Jacksonville announce the birth of twin daughters, Nina Grace and Clare Kathryn, on January 12.

Deaths — Members

Stanford, John A., Ft. Lauderdale ..... Dec. 27, 1951
Sandusky, Clarence M., Jacksonville ..... Dec. 29, 1951

Deaths — Other Doctors

Stutts, Baldwin S., Dunnellon ..... Dec. 27, 1951
Martorell, Abelardo, Tampa ..... Dec. 31, 1951

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Baggs, Wade H., Jr., Tampa
Banks, Cullen W., II, (Col.), Gainesville
Edwards, Harry M., Ocala
Frishkorn, Paul E., Auburndale
Garner, Joe F., Jacksonville
Hodges, William A., Jr., Lakeland
Jensen, Louis C., Jr., Winter Haven
Jones, Frederick B., Chipley
Karelas, George W., Newberry
McKay, Charles F., Lake Butler
Massam, Alfred S., Bartow
Moody, James D., Orlando
O'Donnell, John A., Daytona Beach
Pinkoson, Charles, Gainesville
Price, Robert N., Lakeland
Rahilly, George T. F., Fort Lauderdale
Schildecker, William W., Daytona Beach
Smith, Vincent V., Fort Lauderdale
Thomas, Joseph E., Mulberry
Wiltshire, Joseph A., (Col.), Lake Wales

STATE NEWS ITEMS

Dr. Eugene L. Jewett of Orlando, representing Florida, was one of about 50 doctors appointed from the hundreds attending the Pan-Pacific surgical Congress in Honolulu in November to act as emissary of modern medical science at ceremonies rededicating the ancient Hawaiian healing heiau atop Aiea heights near Honolulu. In effect, modern medicine was admitted to the shrine and thus linked to the ancient Hawaiian art of herbal healing.

Dr. Ruth S. Jewett (Mrs. Eugene L. Jewett) of Winter Park was the only other Florida doctor present at the ceremony.

Dr. Charles Rosenfeld of Miami has returned to his practice after completing a two weeks postgraduate course in the care of premature infants at the New York Hospital, Cornell Medical Center.

Every member of the Board of Governors was present at the December 16 meeting in Jacksonville. The Board met at the call of its chairman, President David R. Murphey, Jr., of Tampa.

Meeting simultaneously with the Board was the Scientific Work Committee of which Dr. James N. Patterson of Tampa is chairman. The committee completed the scientific program for the 1952 convention at Hollywood, April 28-30.

Dr. David Henry Poer of Atlanta, Secretary-Treasurer of the Medical Association of Georgia and Editor of The Journal, has been invited by the Board of Governors to attend the F. M. A. annual meeting in April representing his Association. Dr. Poer had expressed admiration for the progressiveness of the F. M. A. and a desire for an opportunity to see it in action.

Word has been received from Korea that Mr. Harold Parham, on leave of absence from the Bureau of Public Relations, has been promoted to the rank of first lieutenant.

Dr. John D. Milton of Miami presented a paper at the annual meeting of the Florida Obstetric and Gynecologic Society held in St. Petersburg, December 1-2.

Dr. Chas. L. Farrington, St. Petersburg, was the featured speaker at a one-day meeting of public health nurses from the Gulf coast counties. Dr. Farrington was also guest speaker at the meeting in early December of the Tarpon Springs Rotary Club where he spoke on various methods used in correcting deformities in crippled children.

Dr. James N. Patterson of Tampa and Dr. O. Whitmore Burtner of Miami recently conducted a seminar on Hematology in Tampa, sponsored by the Florida Society of Medical Technologists.

Dr. Samuel G. Hibbs of Tampa has been elected vice-president of the Tampa chapter, American National Red Cross.

Dr. James J. Griffitts of Miami explained to the local Rotary Club at a recent meeting the necessity for large numbers of blood transfusions in that area.

Dr. Joseph Perez of DeLand addressed a local Lions Club at a recent meeting on methods of caring for injuries due to atomic explosion.

Dr. John R. Boling, Tampa, has been honored by the St. Joseph's Hospital for his 17 years of service as Chief of Staff.

Dr. Thomas H. Bates of Lake City has been reappointed for the fifth time to the Medical Advisory Committee to the Nation Rehabilitation Commission of the American Legion.

Dr. Walter H. Winchester of Dunedin was the guest speaker at a recent meeting of the Kissimmee Rotary Club.

Dr. William C. Roberts, Panama City, has been elected president of a newly-formed medical-social group. The organization is separate from the county medical society. Other officers include Dr. James A. Poyner, vice-president, and Dr. Harold E. Wager, secretary-treasurer, both of Panama City.

Again this year complimentary subscriptions to "Today's Health" are being sent by the Association to United States Senators and Congressmen, Florida Senators and Representatives, the Governor and members of his cabinet, the Director of the Florida Agricultural Extension Service, and the Florida State Home Demonstration Agent.

Dr. Otho W. Gardner of Greensboro was signally honored by friends and former patients on his 77th birthday December 11. The birthday party was attended by approximately 1,000 people, 500 of whom were Dr. Gardner's "babies." Dr. Gardner estimates that he has delivered over 3,000 babies during his 50 years of medical practice. During this time he was the only physician in Greensboro and served as mayor of the town for 37 years.

Dr. Gardner, a native of Camilla, Ga., came to Greensboro to practice shortly after he received his degree from what is now the Emory University School of Medicine in Atlanta in 1901. He still practices medicine part time in his home.

Mr. Norman J. Ulbright of St. Louis has joined the Association as acting supervisor of its Bureau of Public Relations, which functions under the general direction of Dr. Stewart G. Thompson, Managing Director.

Mr. Ulbright, formerly public relations director of Optimist International, a service club organization, is a graduate of the University of Missouri and comes to the Association with an impressive background in public relations and organization work.

Dr. M. Eugene Flipse, who has been taking postgraduate work in internal medicine and the subspecialty of pulmonary diseases at the Mayo Foundation, plans to spend an additional year at the Foundation studying cardiovascular diseases. Upon completion of his studies, Dr. Flipse plans to re-establish his practice in Miami.

Dr. Bernard J. McCloskey of Jacksonville has returned to his practice following a postgraduate course in cardiovascular diseases at the University of Texas, December 10-15.

Dr. Milton F. Saslaw of Miami announces that courses of instruction in cardiology will be offered at the National Children's Cardiac Home, Miami, in the near future.

Dr. J. Maxey Dell, Sr., Gainesville, was honored on December 14 by the local lodge of the Elks as one of the members present at the organization of the lodge in 1906.

Dr. Ivan W. Gessler of Winter Haven recently spoke before the local Rotary Club explaining the code of ethics of the medical profession. On the program with Dr. Gessler was a member of the legal profession and a newspaperman.

Dr. J. Powell Adams of Panama City was a recent guest speaker at a monthly meeting of a local Parent Teacher's Association. Dr. Adams discussed the importance of contributing blood through the mobile blood unit.

Dr. Richard S. Hodes formerly of Barberville has announced the opening of his offices at 420 West Lafayette Street, Tampa, with practice limited to anesthesiology.

Dr. Walter C. Payne, Pensacola, chairman of the Association's Grievance Committee and member of the Board of Governors, visited the headquarters office in Jacksonville, January 14, to discuss problems in connection with affairs of the Association.

Dr. Henry B. Cordes of Frostproof was honored by the local Rotary Club for 31 years of service to the community. His record was reviewed for the club by Dr. Kenneth Dunham, also of Frostproof.

Dr. Franz H. Stewart of Miami discussed "Ethics of the Medical Profession" at a meeting of a local Exchange Club.

The Georgia Society of Ophthalmology and Otolaryngology will hold its annual meeting Friday and Saturday, March 7 and 8, 1952, at the well known resort hotel, The General Oglethorpe, Wilmington Island, Savannah, Ga. For additional information, write Dr. W. Eugene Matthews, Secretary-Treasurer, Augusta, Ga.

The Southeastern Allergy Association will hold its Seventh Annual Meeting at the Bon Air Hotel, Augusta, Ga., on March 21 and 22, 1952.

Dr. Lewis T. Corum of Tampa presented a scientific paper at the January meeting of the DeSoto-Hardee-Highlands-Glades Medical Society on "Some Common Problems of Early Infancy."

Dr. Hawley H. Seiler of Tampa was the guest speaker at a recent meeting of the Polk County Medical Society held at the Lakeland Yacht Club. His subject was "The Surgical Treatment of Solitary Pulmonary Metastases" and "Indications for Pulmonary Resection in the Treatment of Tuberculosis."

COMPONENT SOCIETY NOTES

Alachua

New officers of the Alachua County Medical Society are Dr. Henry J. Babers, Jr., president; Dr. Henry H. Graham, vice-president; and Dr. Raymond S. Camp, secretary-treasurer, all of Gainesville.

Bay

At the regular monthly meeting of the Bay County Medical Society officers for 1952 were elected as follows: Dr. Charles H. Daffin, president; Dr. Jack Corbitt, vice-president, and Dr. William F. Humphreys, Jr., secretary-treasurer, all of Panama City.

Brevard

At the regular December meeting of the Brevard County Medical Society officers were elected for the year 1952. Dr. James A. Sewell of Melbourne was elected president, Dr. Laurent L. LaRoche of Cocoa was elected vice-president, and Dr. Theodore J. Kaminski of Melbourne was re-elected secretary-treasurer.

Guests at the meeting were doctors from Patrick Air Force Base and the Florida Rapid Treatment Center.

Broward

Guest speaker at a recent meeting of the Broward County Medical Society was Dr. Clarence M. Sharp, Director of the Bureau of Tuberculosis Control, State Board of Health, who spoke on the recent improvements at the state tuberculosis hospital at Lantana.

Dade

Dr. Ralph S. Sappenfield will serve as president of the Dade County Medical Association for 1952. Other officers elected at the regular December meeting include: Dr. Ralph W. Jack, Miami, president-elect; Dr. Benjamin G. Oren, Miami, vice-president; Dr. Nelson Zivitz, Miami Beach, secretary, and Dr. Raymond L. Evans, Miami, treasurer.

Some fifty representatives of press, radio and television in the Miami area were guests of the Association at its third annual medical-press-radio dinner, December 5. The program was under the direction of Drs. L. Washington Dowlen, Edward W. Cullipher and Robert F. Dickey.

DeSoto-Hardee-Highlands-Glades

Officers elected to serve the DeSoto-Hardee-Highlands-Glades County Medical Society for 1952 are Dr. Harold S. Agnew, president; Dr. Gordon H. McSwain, vice-president, and Dr. Charles H. Kirkpatrick, secretary-treasurer, all of Arcadia.

At the regular monthly meeting on January 8, Dr. Lewis T. Corum of Tampa spoke on "Some Common Problems of Early Infancy."

Duval

At the regular December meeting of the Duval County Medical Society, the 1952 officers were elected. They are Dr. Ferdinand Richards, president; Dr. W. W. Rogers, president-elect; Dr. Ernest W. Veal, vice-president; Dr. Joseph A. J. Farrington, secretary, and Dr. Bert H. Malone, treasurer, all of Jacksonville.

The regular January meeting was held Jan. 2 at the Naval Hospital, Naval Air Station, Jacksonville. Members of the society were the guests of the medical staff of the hospital. The program included talks on "Acute Head Injury" with case presentation by Lt. (jg) S. C. Taylor, (MC) USNR; "Malignant Dysgerminoma" with case presentation by Cdr. R. B. Greenman, (MC) USN;

and "Recent Advances in Cardiology" by Cdr. M. M. Driskell, (MC) USN.

Escambia

Officers of the Escambia County Medical Society for 1952 are Dr. Chas. J. Heinberg, Pensacola, president; Dr. Stanley G. Childers, Cantonment, vice-president, and Dr. Raymond B. Squires, Pensacola, secretary-treasurer.

Franklin-Gulf

The following officers for 1952 were elected by the Franklin-Gulf County Medical Society: Dr. John W. Hendrix, Port St. Joe, president; and Dr. William P. Blackmon, Apalachicola, secretary.

Hillsborough

New officers of the Hillsborough County Medical Association include Dr. Sherman B. Forbes, president; Dr. Arthur R. Knauf, president-elect; Dr. C. Frank Chunn, vice-president; Dr. James N. Patterson, secretary; and Dr. Thomas F. Nelson, treasurer, all of Tampa.

The Association met with the Pinellas County Medical Society at their December 3 meeting to hear a talk on "Lobotomy in the Treatment of Disabling Psychoneuroses" by Dr. Walter Freeman, famous brain surgeon of Washington, D. C.

At the regular monthly meeting, January 8, members heard a talk on "Recent Advances in Intracardiac Surgery" by Dr. Robert P. Glover of Philadelphia.

Indian River

Officers elected to serve the Indian River County Medical Society for 1952 include: Dr. P. T. McClellan, president; Dr. John P. Gifford, vice-president; and Dr. William L. Fitts, 3rd, secretary-treasurer. All the officers reside in Vero Beach.

Jackson-Calhoun

At the December meeting of the Jackson-Calhoun County Medical Society, officers were elected. Dr. Albert E. McQuagge of Marianna was elected president; Dr. Grayson C. Snyder of Blountstown was elected vice-president; and Dr. Francis M. Watson of Marianna was elected secretary-treasurer.

Lake

Officers of the Lake County Medical Society for 1952 are Dr. Robert H. Montgomery of Mount Dora, president; Dr. James R. Hanson of Tavares, vice-president; and Dr. J. Basil Hall of Mount Dora, secretary-treasurer.

Dr. William O. Fowler of Orlando was guest speaker at the monthly meeting of the society, December 5. He also showed a film in color on chest surgery.

The society voted to continue through January and February the program furnished by the Bureau of Health Education of the American Medical Association. The series is entitled "Melody of Life" and is broadcast over Station WLBE, Leesburg.

Lee-Charlotte-Collier-Hendry

The newly-elected officers of the Lee-Charlotte-Collier-Hendry County Medical Society are Dr. John S. Stewart, president; Dr. Joseph L. Selden, Jr., vice-president; and Dr. Harvie J. Stipe, secretary-treasurer, all of Fort Myers.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Dr. Ernest W. Ekermeyer of Tallahassee is the newly-elected president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. Dr. Charles F. James, Jr., of Tallahassee was elected vice-president, and Dr. George H. Massey of Quincy was elected secretary-treasurer.

Madison

The new officers of the Madison County Medical Society are Dr. A. Franklin Harrison, president, and Dr. Eugene D. Thorpe, secretary-treasurer, both of Madison.

Manatee

Dr. John E. Granade is the newly-elected president of the Manatee County Medical Society. Other new officers are Dr. Willis W. Harris, vice-president, and Dr. Marjorie L. Warner, secretary-treasurer. All three officers are from Bradenton.

Marion

The following officers for 1952 were elected by the members of the Marion County Medical Society at the December meeting: Dr. Carl S. Lytle, president, and Dr. William J. McGovern, vice-president. Re-elected secretary-treasurer was Dr. Bertrand F. Drake. All officers reside in Ocala.

Dr. Harry M. Edwards of Ocala spoke on "Diarrhea in Infants and Children."



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Monroe

Officers for the Monroe County Medical Society for 1952 are Dr. James B. Parramore, president; Dr. Leonard H. Conly, vice-president; and Dr. Herman K. Moore, secretary-treasurer, all of Key West.

Nassau

Dr. David G. Humphreys was re-elected president of the Nassau County Medical Society for 1952. Also re-elected were Dr. Benjamin F. Dickens, vice-president, and Dr. John W. McClane, secretary-treasurer. All three officers are from Fernandina.

Orange

The newly-elected officers of the Orange County Medical Society are as follows: Dr. Carl S. McLemore, president; Dr. G. Tayloe Gwathmey, president-elect; Dr. Edgar E. Hitchcock, vice-president; Dr. James B. Glanton, secretary, and Dr. Joseph C. Hayward, treasurer, all from Orlando.

At the regular December meeting of the society, Mr. Jefferson Hamilton, consulting architect for the proposed medical school at Gainesville, was guest speaker. He discussed the present plans for this medical school.

Palm Beach

Dr. Cecil M. Peek, West Palm Beach, is the new president of the Palm Beach County Medical Society. Other officers include Dr. Alvin E. Murphy, Palm Beach, vice-president; Dr. Graham W. King, Jr., Delray Beach, president-elect; Dr. David A. Newman, West Palm Beach, secretary; and Dr. Frederick K. Herpel, West Palm Beach, treasurer.

The first edition of a Directory of the Physicians and Surgeons in Palm Beach County has been issued by the Palm Beach Medical Society .

Pasco-Hernando-Citrus

At the regular monthly meeting of the Pasco-Hernando-Citrus County Medical Society on December 13, the following officers were elected for the year 1952: Dr. William H. Walters, Jr., Lacoochee, president; Dr. George R. Creekmore, Brooksville, and Dr. Karl T. Humes, Bushnell, vice-presidents; and Dr. W. Wardlaw Jones, Dade City, secretary-treasurer.

Pinellas

The list of officers who will serve the Pinellas County Medical Society during 1952 appeared in the December Journal.

At the December meeting of the Society, Dr. Walter Freeman, neuro-psychiatrist and neuro-surgeon of Washington, D. C., spoke on "Lobotomy in the Treatment of Disabling Psychoneuroses," to a joint assembly of members of the Pinellas and Hillsborough Societies.

The regular monthly meeting of the Society was held on January 7 at the Detroit Hotel in St. Petersburg. Dr. William R. Tench of Clearwater presented a scientific paper on "Electrolyte Balance of the Body."

Polk

At its regular meeting in December, the Polk County Medical Society held its annual election of officers. Elected were Dr. Ivan W. Gessler of Winter Haven, president; and Dr. Milo H. Holden of Bartow, vice-president. Dr. Jere W. Annis of Lakeland was re-elected secretary-treasurer.

At the regular meeting in January, Dr. Hawley H. Seiler of Tampa was guest speaker. His subject was "The Surgical Treatment of Solitary Pulmonary Metastases" and "Indications for Pulmonary Resection in the Treatment of Tuberculosis."

Putnam

Dr. Lawrence G. Hebel was elected president of the Putnam County Medical Society for 1952, and Dr. Bennie J. Massey was elected secretary-treasurer. Both are from Palatka.

St. Johns

At its regular meeting in December, the St. Johns County Medical Society held its annual election of officers. Elected were Dr. Charles C. Grace, president; Dr. George C. Hopkins, vice-president; Dr. James J. DeVito, secretary; and Dr. Reddin Britt, treasurer, all of St. Augustine.

St. Lucie-Okeechobee-Martin

The newly-elected officers of the St. Lucie-Okeechobee-Martin County Medical Society are Dr. Richard F. Sinnott, president, and Dr. John T.

Advertisement



From where I sit *by* Joe Marsh

Jiggs Gets Four "Hot-Foots"

Cappy Miller's bought himself a new car. We won't be seeing his old jalopy bouncing over the back roads any more. I'm going to miss it, too.

Many a morning Cappy and I drove off in that rattletrap for a day's hunting or fishing. We'd pile rods or guns in back, and prop open the trunk compartment—so Jiggs, Cappy's pointer, could jump in and go along.

They say when Cappy brought the new car home he opened up the hood to show off the engine—and poor old Jiggs hopped right in! Figured it was the trunk. He hopped right out in a hurry, too. That cylinder head was mighty hot.

From where I sit, old habits are hard to shake, once they get a hold. For instance, too many people are still in the habit of trying to run their neighbors' lives—telling them how to act, how and where to practice their profession, whether or not to enjoy a glass of beer. I say that kind of thinking's outmoded . . . ought to be turned in for a new model!

Joe Marsh

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McDermid, vice-president. Re-elected secretary-treasurer was Dr. Adrian M. Sample. All officers are from Ft. Pierce.

Dr. Robert F. Dickey of Miami, guest speaker, spoke on "Reparative Surgery in Children."

Seminole

Officers elected to serve the Seminole County Medical Society during 1952 are: Dr. Julian N. Tolar, president; Dr. William V. Roberts, vice-president; and Dr. Frank L. Quillman, secretary-treasurer, all of Sanford.

Suwannee

Dr. Edward G. Haskell, Jr., of Branford is the newly-elected president of the Suwannee County Medical Society. Other officers include Dr. Irby H. Black, vice-president; and Dr. J. Dillard Workman, secretary-treasurer, both of Live Oak.

Volusia

Officers of the Volusia County Medical Society for 1952 were elected at the December meeting. Dr. J. Richard West was elected president; Dr. C. Robert DeArmas was elected vice-president, and Dr. Robert L. Miller was re-elected secretary-treasurer. All are from Daytona Beach.

Walton-Okaloosa

Officers of the Walton-Okaloosa County Medical Society for 1952 are Dr. William D. Cawthon, DeFuniak Springs, president; Dr. Allen A. Enzor, Crestview, vice-president; and Dr. Edgar H. Myers, DeFuniak Springs, secretary-treasurer.

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Washington-Holmes

Officers of the Washington-Holmes County Medical Society for 1952 are Dr. George W. Carter, president, and Dr. Bayllye W. Dalton, secretary-treasurer, both of Chipley.

BOOKS RECEIVED

Rehabilitation Nursing. By Alice B. Morrissey. Pp. 299. Price, $5.00. New York, G. P. Putnam's Sons, 1951.

From the pen of the Supervisor of Nursing Service and Instructor of the Rehabilitation Center, Department of Physical Medicine and Rehabilitation, Bellevue Hospital, New York City, this book embodies the author's sound philosophy of patient care and offers the reader an opportunity to gain knowledge that can be applied to every area of nursing. Although the special theme is rehabilitation nursing, it contains so much good basic nursing that it should prove both profitable and inspirational to all nurses and nursing students who take pride in their vocation and harbor a genuine desire to aid their patients in restoring themselves.

This unique contribution to present day nursing literature presents first a short historical approach and then offers specific details of nursing technics and procedures to be employed in caring for patients who suffer from some of the more common disabling conditions. The methods suggested are entirely patient-centered. The role of the nurse is pictured in the combined capacity of nurse, teacher, helper and friend. Great emphasis is placed upon the psychologic problems involved in teaching the patient to assist in the rehabilitation process.

In the foreword, Dr. Howard A. Rusk commends this book as a guide to the nurse in helping minimize the disability resulting from many chronic disabling diseases medical science cannot as yet prevent or cure and as an aid to her in helping her patients learn to live within the limits of their disabilities and to the hilt of their capabilities.



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OBITUARIES

Homer Jackson Moore

Dr. Homer Jackson Moore of Miami died in Jackson Memorial Hospital in that city on Sept. 28, 1951, of acute pancreatitis. He was 40 years of age. Interment took place in Arlington National Cemetery, Arlington, Va., on October 3.

The son of Joseph and Dora Moore, Dr. Moore was born in Dallas, Tex., on April 22, 1911. He received his early education in Dallas and in 1941 was awarded the degree of Doctor of Medicine from the University of Texas School of Medicine in Galveston. Immediately thereafter, he entered the Medical Corps of the United States Navy and served an internship at the United States Naval Hospital, San Diego, Calif. For nine years he continued on active duty with the Navy, which included service in the Pacific area where he was in charge of the dispensary at Henderson Field, Guadalcanal, for sixteen months. In 1946, he came to Miami as a lieutenant commander at Miami Naval Air Station, Opa-Locka.

Because of physical disability, Dr. Moore was retired from the Navy on May 1, 1949. That same year he entered the private practice of medicine in Miami.

Dr. Moore was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association.

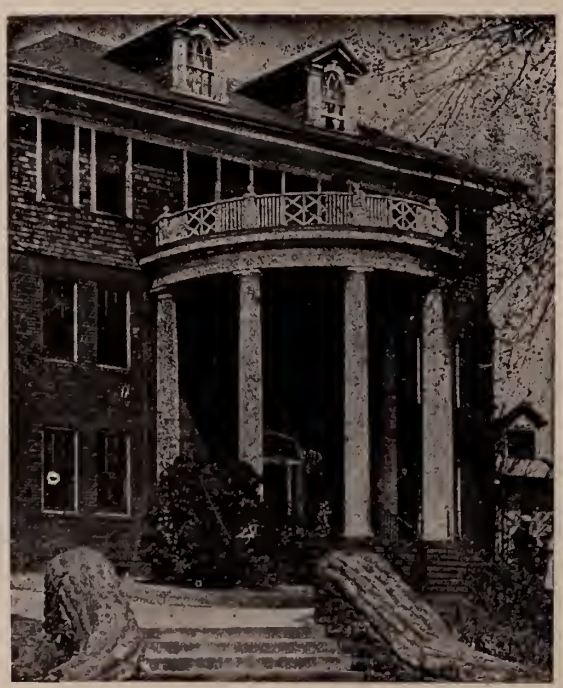
Surviving are the widow, Mrs. Dorothy Hambrick Moore; one son, Homer Jackson, Jr.; and one daughter, Dorothy Helen, of Miami; and his mother, two brothers and three sisters, all of Dallas.

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Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

Joseph Haskell Chiles

Dr. Joseph Haskell Chiles of Orlando died on Aug. 6, 1951 at the age of 74 years.

A Floridian, Dr. Chiles was born on Feb. 14, 1877 in Madison County. His preliminary education was received at St. Johns Military Academy, Ossining, N. Y., and Florida State Agricultural and Mechanical College in Lake City. He was graduated from the Medical College of Virginia, Richmond, Va., on May 28, 1905.

After practicing in Virginia for three years, Dr. Chiles returned to Florida in 1908. He practiced in Oviedo, Floral City and Clermont prior to 1917, when he volunteered for the Medical Corps of the Army in World War I. He received a fellowship in medicine at the University of London, England, in 1919. In August of that year he was discharged from the Army with the rank of captain.

Upon entering the practice of medicine in Orlando in September 1919, Dr. Chiles was associated with the late Dr. C. D. Christ for two years. He was president of the Orange County Medical Society in 1929. From 1936 to 1939 he practiced in Holopaw and was county physician for Orange County from 1939 to 1941. He returned to practice in Holopaw and was again county physician from 1945 until October 1948. He resigned because of failing health and resumed a limited private practice. Locally, he was a member of the Methodist Church and the Masonic Lodge.

In addition to holding membership in the Orange County Medical Society, Dr. Chiles was for forty years a member of the Florida Medical Association, the last five years as a life member. He was also a member of the American Medical Association.

Surviving is the widow, the former Ida Howard of Pulaski, Va., to whom he was married on June 17, 1908. Other survivors include two daughters, Miss Betty S. Chiles of San Francisco, Calif., and Mrs. L. S. Algee of Orlando; one son, Seaborn H. Chiles of Palo Alto, Calif., and six grandchildren.



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James Keene Ward, M. D., Associate Physician
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PROVIDES A NUTRITIONALLY ADEQUATE* FORMULA

PROTEIN

Baker's Modified Milk supplies 3.5 to 4 grams of milk protein per kilogram of body weight per day when the total feeding is 2½ fluid ounces of normal strength dilution** per pound of body weight. The milk protein in Baker's also provides adequate amounts of all the essential amino acids.

CARBOHYDRATE

The carbohydrates in Baker's Modified Milk are lactose and dextrose. The dextrose which requires no digestion is readily assimilated. The lactose is slowly digested and absorbed. This combination of sugars is less likely to lead to digestive disturbances than if a single sugar were used. The carbohydrate content (7% at normal dilution**) provides adequate calories to spare the protein for its normal function of tissue building and repair.

FAT

The fat-carbohydrate ratio (approximately 1:2) is adequate to insure proper fat metabolism. The butter fat has been replaced by other fats containing less of the undesirable very low and very high molecular weight fatty acids. The added fats have also been selected to provide adequate amounts of the essential unsaturated fatty acids.

MINERALS

Baker's Modified Milk contains an adequate mineral content with the calcium-phosphorus ratio falling within the optimum range (1.3 to 1). Since cows milk contains only a trace of iron, sufficient iron ammonium citrate has been added to supply 7.5 milligrams of iron per quart of normal dilution.**

VITAMINS

Baker's Modified Milk supplies adequate amounts of all recommended vitamins except Vitamin C.

These are the reasons why infants thrive on Baker's Modified Milk—a nutritionally adequate* formula.

★

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*When fed in normal quantities, provides amounts of proteins, vitamins (except C), minerals and essential unsaturated fatty acids equal to or exceeding the daily recommended allowances of The Food and Nutrition Board of the National Research Council.

**Dilute with equal parts of water.

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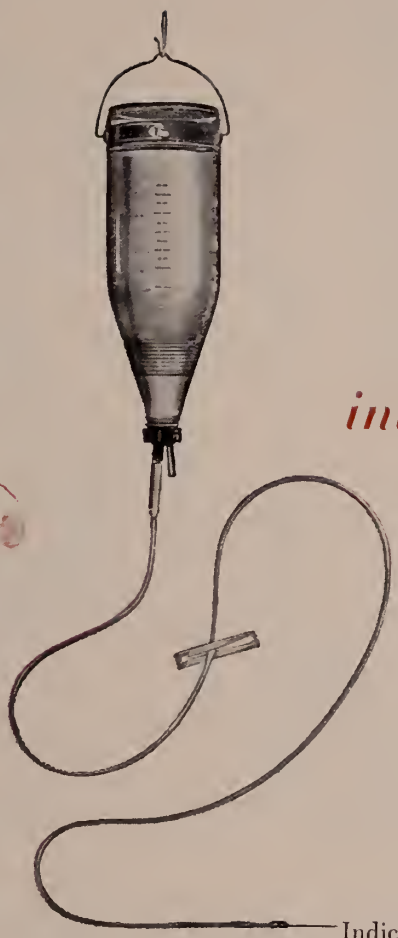
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GYNECOLOGY—Intensive Course, Two Weeks, starting February 18, March 17. Vaginal Approach to Pelvic Surgery, One Week, starting March 3, March 31.

OBSTETRICS—Intensive Course, Two Weeks, starting March 3, March 31.

MEDICINE—Intensive General Course, Two Weeks, starting May 5. Electrocardiography & Heart Disease, Two Weeks, starting March 17. Gastroenterology, Two Weeks, starting May 19. Hematology, One Week, starting June 16.

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Lakeland	206 Marble Arcade	Panama City	142 Harrison Avenue
West Palm Beach	410 Datura Street	Pensacola	501 Theisen Building
Orlando	209 Slayton Building		

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
da Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '52
da Medical Districts	William C. Roberts, Panama City	Council Chairman	
Northwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Panama City, 1952
Northeast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Daytona Beach, 1952
Southwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	St. Petersburg, 1952
Southeast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Ft. Pierce, 1952
da Specialty Societies			
emy of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	Hollywood, Apr. 27, '52
gy Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	" "
thesiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
ter, Am. Coll. Chest Phys.	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
i. and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
h Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
t Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	Miami, May 8-10, '52
strial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	Hollywood, Apr. 27, '52
ology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
nd Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
hial & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	" "
ppedic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	" "
ty of Pathology	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Laudardale	" "
tric Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	" "
ologic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	" "
logical Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
gical Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
da—			
sic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 7, '52
od Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
e Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
e Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 27, '52
ncer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
ntal Society, State	John I. Todd, D.D.S., Jacksonville	Tom Price, D.D.S., Miami	Jacksonville, Apr. 20-23, '52
spital Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Beach, Nov. '52
dical Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	Jacksonville, June 29-July 1, '52
dical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 23-28, '52
rses Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
rmaceutical Association, State	Mr. Euless Watford, Chipley	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-21, '52
olic Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct., '52
berculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Pt. St. Joe	
man's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	Hollywood, Apr. 27-29, '52
ican Medical Association	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Chicago, June 9-13, '52
M.A. Clinical Session	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
ern Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, 1952
ma Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19, '52
gia, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 11-14, '52
Hospital Conference	Edwin B. Peel, Atlanta	Mr. R. G. Ramsey, Jr., Memphis	Atlanta, Apr. 16-18, '52
eastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath. B. MacInnis, Columbia, S. C.	Augusta, Ga., Mar. 21-22, '52
eastern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	Boca Raton, Apr. 2-5, '52
eastern Surgical Congress	Joseph S. Stewart, Miami	B. T. Beasley, Atlanta	Atlanta, Mar. 10-13, '52
Coast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct., '52



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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Hon.	MEMBERS Regular	COUNCILOR
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		0	21	
	Escambia *Santa Rosa*	Chas. J. Heinberg, M.D. Box 151 Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	9	70	
	Franklin-Gulf	John W. Hendrx, M.D. Port St. Joe	William P. Blackmon, M.D. Apalachicola	Last Wednesday	0	7	A-1-52 Arthur J. Butt, M.D. Pensacola
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	1	15	
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	2	14	
	Washington-Holmes	George W. Carter, M.D. Chipley	Bayllye W. Dalton, M.D. Chipley		2	3	
	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	0	16	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	3	53	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		0	8	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		0	3	
	Taylor *Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	0	3	213
B	Alachua *Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	0	46	
	Duval *Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	7	242	
	Marion *Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	1	26	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	1	9	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 581 Palatka	2nd Tuesday 6:00 P.M.	0	11	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	0	15	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	0	20	
	Lake *Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	1	25	
	Orange *Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	5	147	B-4-53 Eugene L. Jewett, M.D. Orlando
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	0	15	
	Volusia *Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	3	72	628
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	3	163	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	0	20	
	Pasco-Hernando-Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	1	12	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	13	166	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	1	41	
	DeSoto-Hardee-Highlands-Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	0	25	
	Lee-Charlotte-Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	0	23	C-6-52 Leldon W. Martin, M.D. Sebring
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	6	80	530
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	0	7	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	1	107	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	St. Lucie-Okeechobee-Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	0	16	
	Broward	M. Austin Lovejoy, M.D. 409 Blount Bldg. Ft. Lauderdale	Thomas L. Roberts, Jr., M.D. 408 Blount Bldg. Ft. Lauderdale	4th Tuesday 8:00 P.M.	6	75	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	27	554	D-8-53 Donald W. Smith, M.D. Miami
		James B. Parramore, M.D. Box 336	Herman K. Moore, M.D. 600 Elizabeth St.	2nd Thursday 8:00 P.M.	0	10	

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YOU ARE INVITED TO VISIT OUR BOOTH AT STATE MEDICAL MEETING, APRIL 27-30 AT HOLLYWOOD BEACH HOTEL. WE WILL HAVE ON DISPLAY ITEMS THAT ARE NEW AND NOT ORDINARILY CARRIED AROUND BY DETAIL MEN.

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The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XXXVIII MARCH, 1952 No. 9

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Nathaniel M. Levin

Gynecologic Causes of Pelvic Pain
Joseph W. Douglas

Surgical Treatment of Traumatic Chylothorax
Kenneth A. Morris and Rothwell C. Polk

The Rugged Individualist's Way of Life
An Editorial

Annual Meeting Program — Page 630

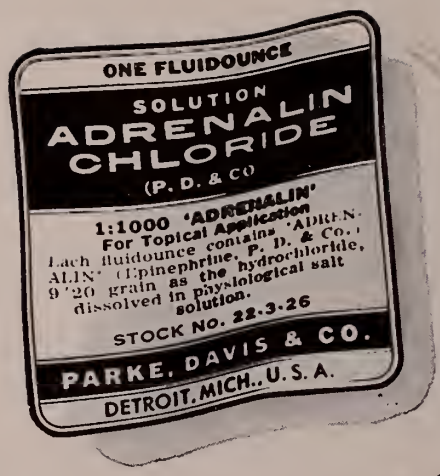
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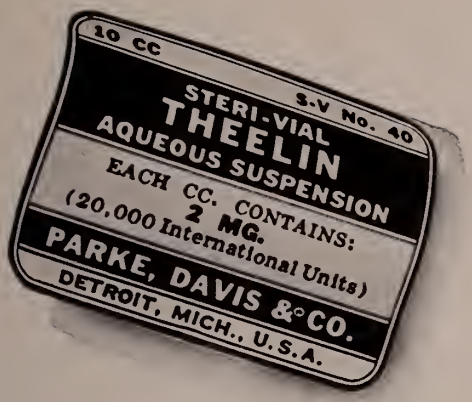
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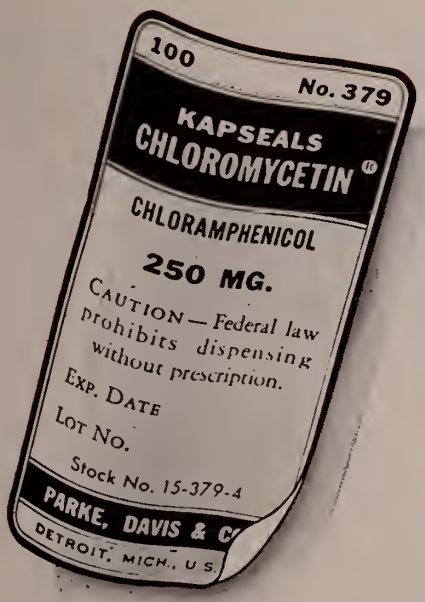


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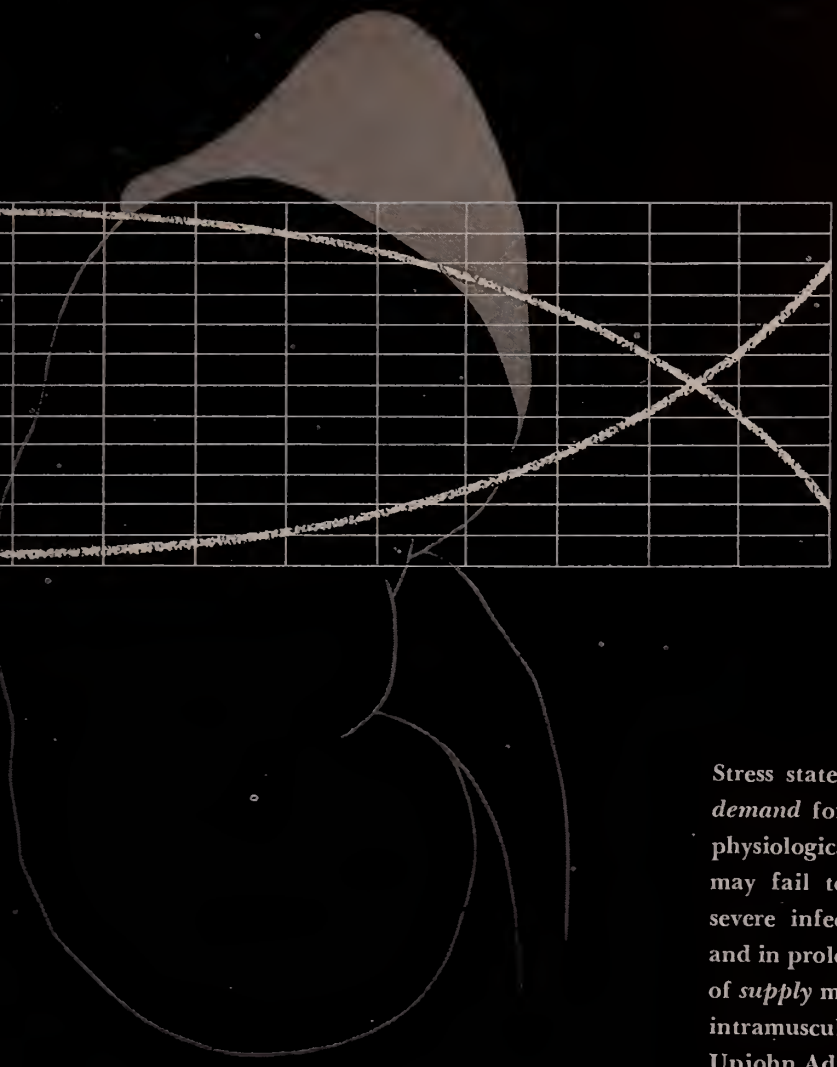
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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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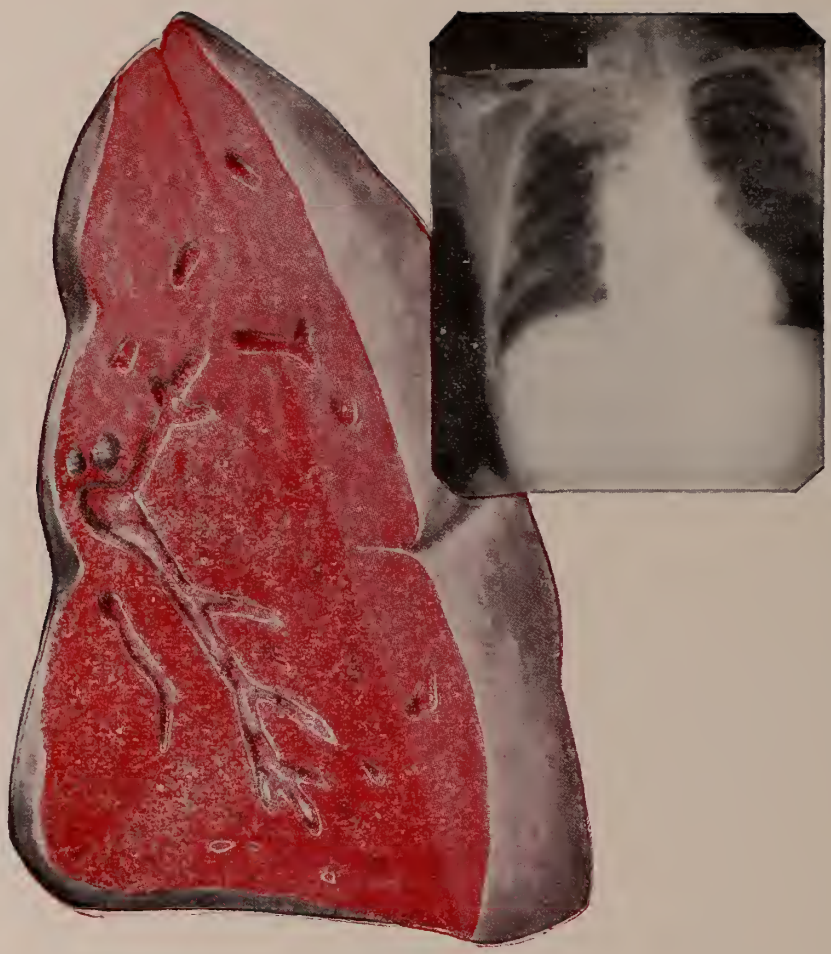
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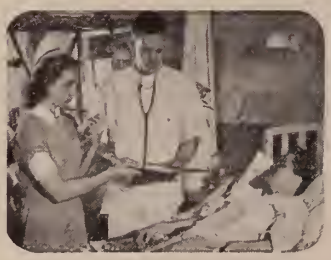
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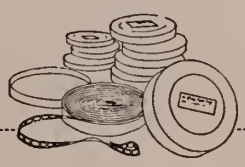


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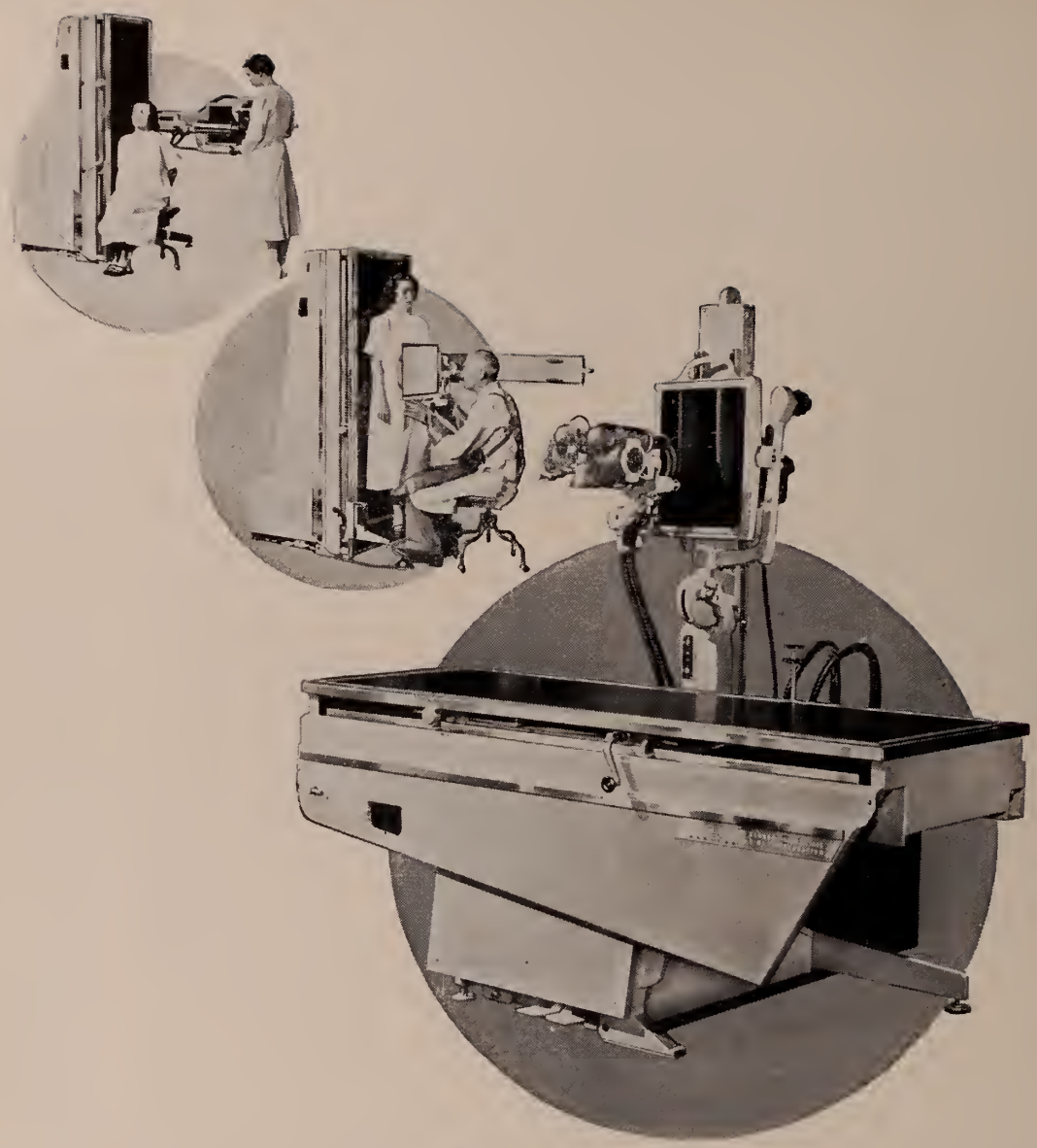
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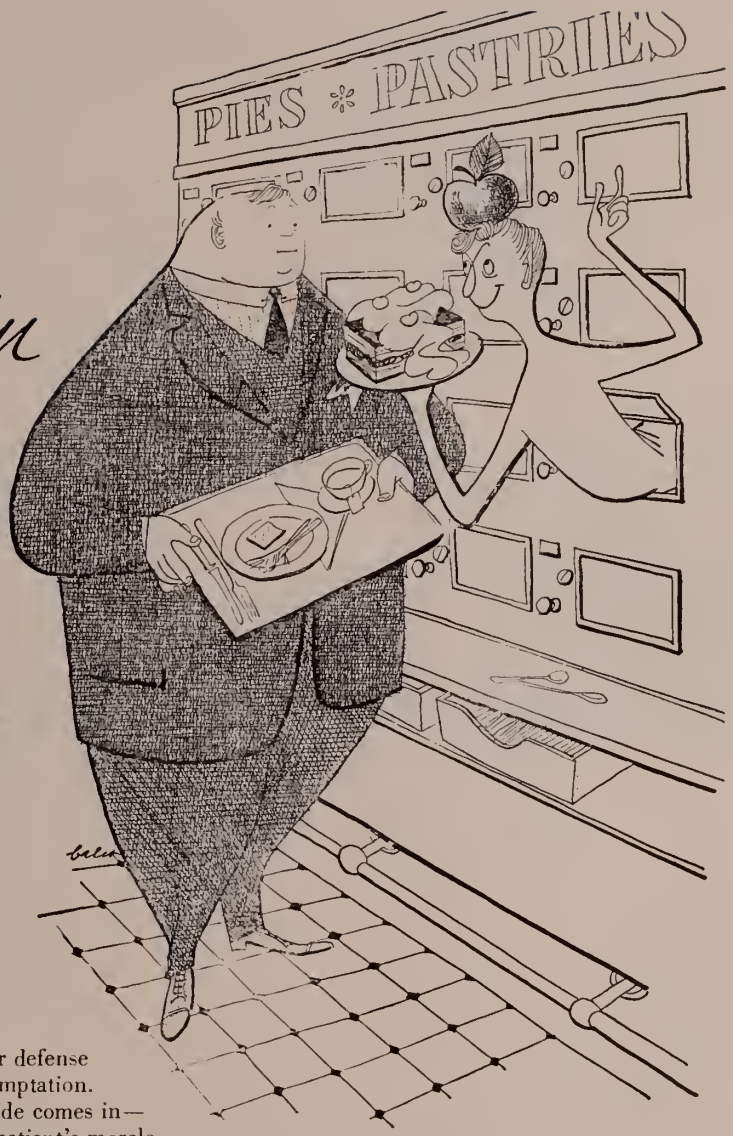
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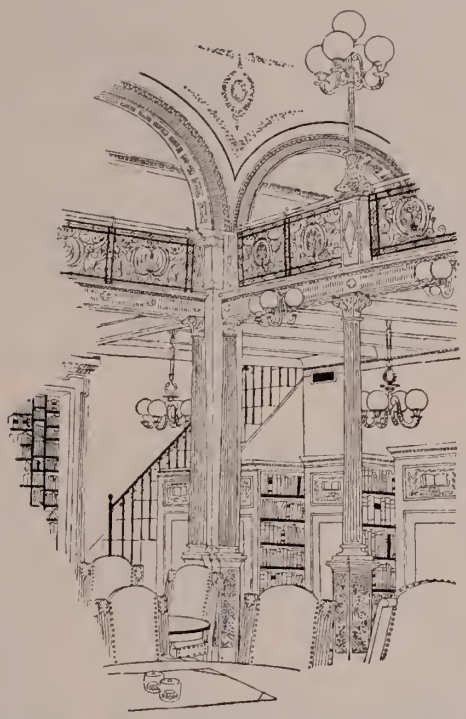
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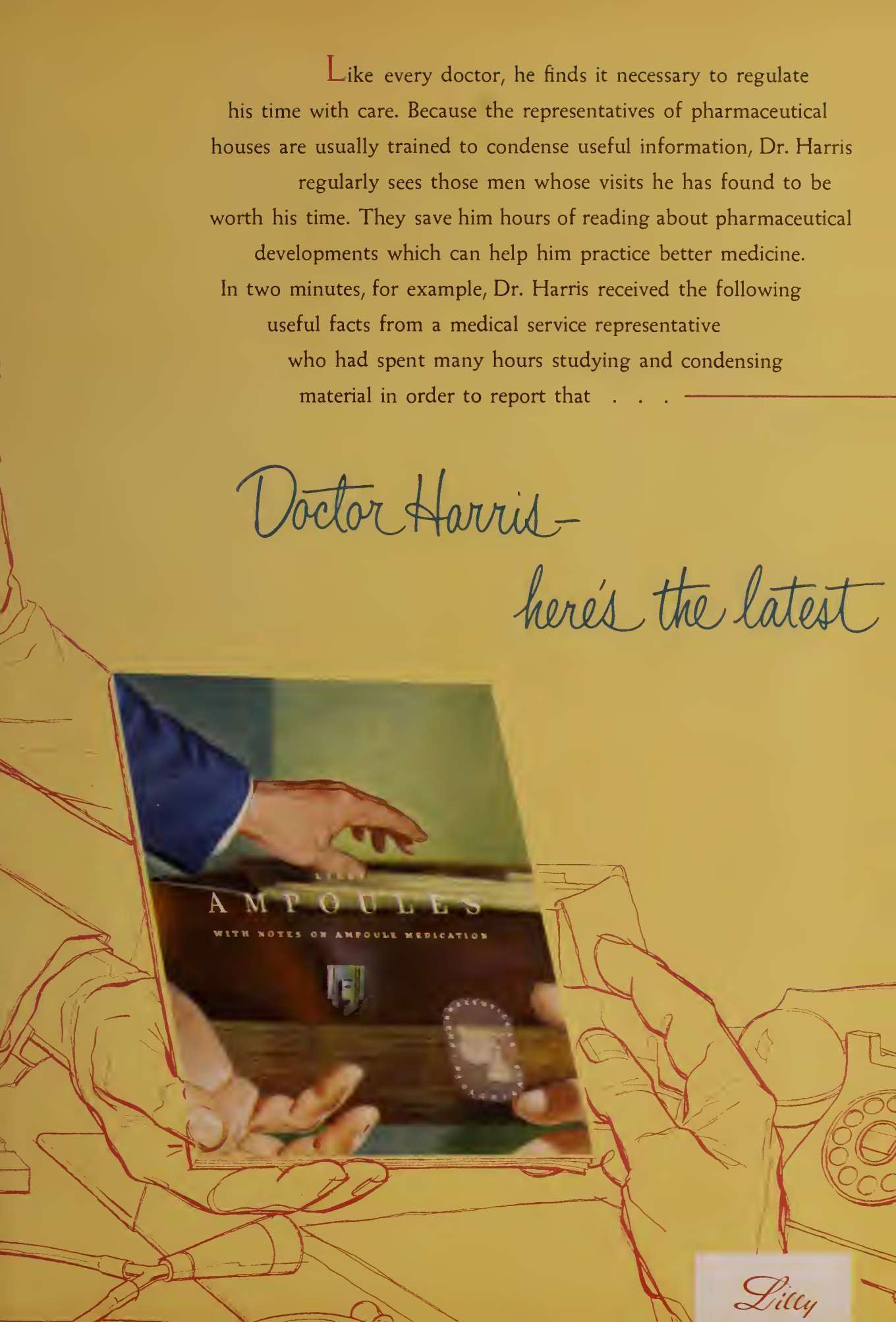
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Volume XXXVIII | Jacksonville, Florida, March, 1952 | No. 9

Foreign Bodies in the Larynx, Bronchi and Esophagus

NATHANIEL M. LEVIN, M.D.
MIAMI

In children, the initial symptoms of a foreign body in the larynx, bronchi or esophagus may be those of a serious emergency. The infant or child playing with a small toy, or eating candy or nuts, chokes over the object, which is accidently aspirated into the tracheobronchial tree, or lodges in the esophagus.

Occasionally a foreign body is accidentally discovered, weeks or months following the accident, when the patient is being studied for asthma, tuberculosis or a chronic pneumonia.[1] Roentgen examination and/or bronchoscopy will reveal the true condition (figs. 1 and 2).

Etiology

The main causes of foreign body in the air and food passages are carelessness and unconsciousness.[2] The factors are: (1) personal, as age (99 per cent occur in children); occupation (work or play) or social conditions (poverty); (2) carelessness, as eating rapidly while talking or playing; placing pins and needles in the mouth; (3) failure of normal protective mechanisms, as sleep, unconsciousness, epileptic seizures or alcoholic incoordination, and aspiration during general anesthesia.

Initial Symptoms of Foreign Body

Whether foreign bodies lodge in the air or food passages, the initial symptoms are often the same, namely, choking, gagging, coughing or wheezing, sometimes followed by a symptomless interval which is misleading (figs. 3 and 4).

Laryngeal or Laryngotracheal Foreign Bodies

Initial symptoms of foreign bodies in the larynx are the same as those mentioned, followed by hoarseness, croupy cough, sometimes loss of voice, at times hemoptysis, dyspnea, and/or cyanosis. Wheezing may occur; the subjective sensation of foreign body may be described by older children and adults. Restlessness, due to air hunger, is an important sign in young children.[2] Indrawing of the suprasternal notch is a serious sign.

Complete Laryngeal Obstruction

Death may follow immediately when laryngeal obstruction is complete, unless the foreign body is removed or a tracheotomy performed. If the foreign body is not immediately obstructive, it may become so later, as edema of the subglottic portion of the larynx develops.

Tracheal Foreign Bodies

Foreign bodies in the trachea give the same signs and symptoms as those occurring in laryngeal obstruction; if the foreign body is loose, it may be palpated by the fingers over the trachea, and a loud "audible slap" may be heard as the foreign body strikes the narrow subglottic area on expiration.[2] A loud wheeze may be heard at the open mouth (fig. 5).

Bronchial Foreign Bodies

Foreign bodies in the bronchi produce the same initial symptoms. Later, there may be a cough and

---

Presented before the Dade County Medical Association, Miami, Fla., Aug. 7, 1951.

Presented in the Scientific Exhibits, Seventy-Seventh Annual Meeting, Florida Medical Association, Hollywood, April 22-25, 1951.

From the Chevalier Jackson Bronchoscopic Clinic, Temple University Hospital, Philadelphia, 1932-1940.

From the Otolaryngologic and Bronchoscopic Services of the Jackson Memorial, Mt. Sinai, U. S. Veterans, St. Francis, and Dade County hospitals, Greater Miami, from November 1945.



Fig. 1. — Specimens from Collection.

Upper left: Coins and discoid objects, usually removed from the upper portion of the esophagus.

Upper right: Pins and safety pins. These sometimes present difficult technical problems.

Upper center: Rectangular black plastic fragment from a toy, measuring 1 by 1/4 inch, removed from the upper part of the trachea of an infant. Serious emergency — tracheotomy required two days following removal by endoscopy.

Tacks: One removed from the esophagus of an infant; the other removed from a bronchus of a 10 year old boy, who did not know that he had a foreign body. Probably swallowed accidentally in food. Removed, much corroded, after three to six month interval.

Dental plates: To left, partial dental plate removed from the esophagus of a sailor flown in from a merchant vessel at sea; note three hooks which added to the difficulty of removal. Dental plate (center) with four teeth, unusually large object, removed through the endoscope from the midthoracic portion of the esophagus.

Middle right: Seeds, fragments of peanuts and other vegetable foreign bodies. These produce most serious inflammatory reactions.

Lower left: Cockleburs ("stickers"), removed from the larynx of 6 adults and 1 child. They produce most painful symptoms and loss of voice.

Lower center: Jackstones, removed from the esophagus of children; one was admitted to the polio ward with a diagnosis of "bulbar polio" because of symptoms of dysphagia and stiff neck. Roentgen examination gave the diagnosis.

Lower right: Bones of beef and chicken; they have sharp edges and can be dangerous. Usually they are removed from the esophagus of adults, but they have been lodged in the trachea and bronchi.

wheezing. This wheeze is a prominent and important symptom, particularly in children. The wheeze may be wrongly diagnosed as asthma (fig. 6). Shortness of breath and pain in the chest may develop later; they are indicative of developing atelectasis or emphysema; both are the result of bronchial obstruction.

A small foreign body can be aspirated into a bronchus without immediate symptoms; later it may be discovered in a routine examination of the chest. Often there is a period of quiescense as the foreign body becomes fixed in a main or branch bronchus; the initial cough may or may not disappear. With the onset of obstruction and infection, the subsequent signs and symptoms will depend on the type of phenomenon which occurs, such as atelectasis, emphysema or a combination of both. The right main bronchus is the seat of foreign body most frequently, due to its almost direct extension from the trachea. The left main bronchus leaves the bifurcation at a more acute angle.



Fig. 2. — Specimens from Collection.

Left to right, upper row: Jackstone (esophagus); chicken bone (trachea); 25¢ piece (esophagus); pieces of stone, hard seed (ear); screw (left main bronchus).

Left to right, lower row: Double coins, 2 pennies and 5 and 10¢ pieces, which add to technical difficulties of removal; needle, spontaneously perforated through the esophagus, removed by external incision; identification bracelet from the esophagus of a 3 year old boy; ragged-edge gear (esophagus); thumb tacks from the esophagus of an infant.



Fig. 3. — Chicken bone in the trachea. Severe respiratory symptoms, including dyspnea.

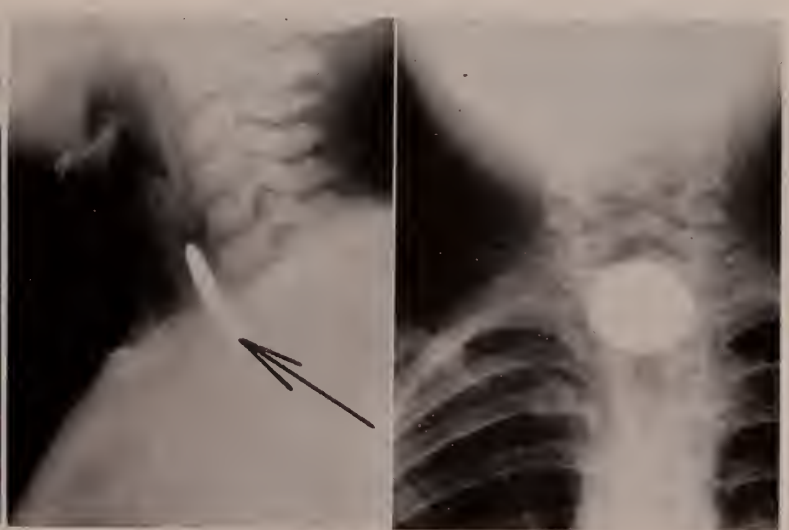


Fig. 4. — Coin, removed from the upper part of the esophagus of a child. The main symptoms were dysphagia and cough with drooling of saliva.

Organic foreign bodies, such as peanuts and others, are most irritating to the mucosa; the resulting inflammatory swelling causes a more complete type of obstruction and with great rapidity.[2]

The classical physical signs of emphysema and atelectasis are well known: In emphysema, there is a shifting of the heart towards the uninvolved (normal) side, with return to the normal position on inspiration; the diaphragm is depressed on the involved (diseased) side. In atelectasis, a shifting of the mediastinum toward the involved side takes place, with the rise of the diaphragm. The opposite side may show compensatory emphysema.

Foreign bodies remaining in the tracheobronchial tree over a long period[3] may give signs and symptoms which simulate pulmonary tuberculosis, abscess of the lung, or bronchiectasis. A cough develops, with purulent expectoration, hemoptysis,[4] low grade fever, loss of weight, and in advanced cases, clubbing of the finger tips. Clinical findings are entirely variable, and depend upon the duration and degree of obstruction.



Fig. 5. — Toy whistle, removed from the trachea of a child who aspirated it while blowing on a horn.

Nonopaque Foreign Bodies

Foreign bodies which are nonopaque are sometimes difficult to diagnose. If such a body is lodged in a bronchus, without causing obstruction to the inflow and outflow of air, a wheezing sound is heard over the chest, or at the open mouth; this is a most important sign. Roentgenograms on inspiration and expiration may show a mediastinal shift (fig. 7).

Metallic Foreign Bodies

Screws, pins and other metallic foreign bodies may cause physical signs only after a prolonged residence in the bronchus if they are small, and much sooner if large and obstructive (fig. 8).



Fig. 6. — Screw, unrecognized for many months, removed from the left main bronchus of a child who was being treated for "asthma."

Vegetable Bronchitis

Vegetable bronchitis presents a serious situation which requires special consideration. It is an acute inflammatory reaction usually occurring in children, due to the aspiration into the trachea or bronchi of organic foreign bodies such as peanuts, beans, bits of leaves, and grass. Children who have inhaled this type of foreign body become violently ill quickly, with a high fever and cough.[2]

A bean is a particularly dangerous foreign body, for it swells quickly to many times its original size; it may obstruct not only the main bronchus but also the trachea, causing suffocation. This situation requires emergency endoscopic examination and removal of the foreign body. At times a foreign body may be fragmented into many small pieces, and each piece must be removed, sometimes requiring several repeat endoscopic procedures.

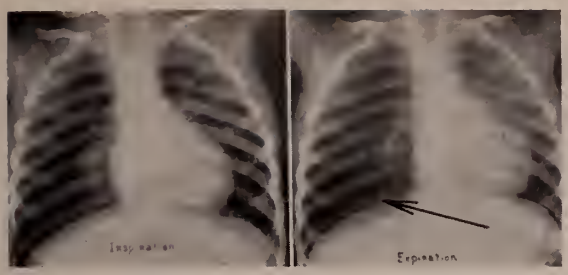


Fig. 7. — Obstructive emphysema of the right lung, due to bronchial obstruction by fragments of peanut kernel. Expiration roentgenogram shows the distended right lung and shifting of the heart to the uninvolved side (to the left).

Thick bronchial secretions are aspirated at the same time. Following each procedure, there is a lessening of wheezing and rales.[3]

Foreign Bodies in the Esophagus

Foreign bodies in the esophagus give rise to the initial symptoms of gagging, choking or coughing. Later, there may develop painful swallowing or complete dysphagia. The patient sometimes complains of substernal pain with radiation to the back, in the interscapular area. Some patients have difficulty in swallowing saliva. Respiratory symptoms may follow, by overflow of the esophageal secretions into the tracheobronchial tree, or because of the compression of the soft posterior wall of the trachea by the esophageal foreign object.

Sometimes a foreign body may erode through the esophagus causing a tracheoesophageal fistula. Fishbones and bones of chicken or beef produce intense pain on swallowing; patients with such foreign bodies cannot be talked out of their symptoms (figs. 9, 10, and 11). If the complaint of foreign body is persistent, it is the duty of the physician to eliminate completely this possibility. Infants sometimes refuse to swallow solid foods, or even liquids, in the presence of a foreign object. Blood may be found in the mouth or may be expectorated.[4]

The Diagnosis of Foreign Body

In the diagnosis of foreign body, the history is most important, especially the initial symptoms, which subside before complications follow. The adult patient or older child can tell that he has gagged or choked over a foreign body, or a piece of food; the mother may relate that the infant was playing with some small object which is now missing, and that the child was found coughing, choking or cyanotic on the floor. Such a case must be followed through, to the satisfaction of the physician and the parent. Finding blood in the mouth in a child should make one most suspicious.[4] The very young child cannot give a history; the older person may have long forgotten that he had choked over a foreign body, and remembers only after its removal and demonstration.

Physical examination for the exclusion of a foreign body includes examination of the nose, mouth and tonsils, and inspection of the pharynx and larynx with the laryngeal mirror. The neck is



Fig. 8. — Showing open safety pins at various levels in the gastrointestinal tract. Left to right: In the hypopharynx; in the lower portion of the esophagus, above the diaphragm; open safety pin in the stomach.



Fig. 9. — Bone in the upper part of the esophagus. This picture is misleading since only the edge is in view. The bone was large with sharp edges.



Fig. 10. — Pin in the hypopharynx and the upper portion of the esophagus, easily removed.



Fig. 11. — Partial dental plate with four teeth and three hooks, removed from the esophagus of a merchant sailor flown in by the United States Coast Guard from a ship at sea.

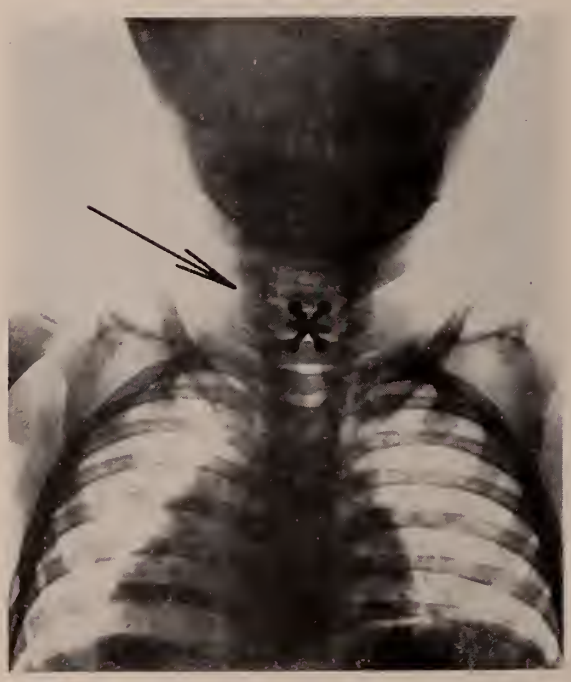


Fig. 12. — Jackstone in the upper part of the esophagus. There was no history of foreign body. The child was admitted to the polio ward with a diagnosis of "bulbar polio." The symptoms were dysphagia, salivation and stiffness of the neck. Roentgen examination disclosed the true pathologic condition.

palpated for subcutaneous emphysema or swelling. Routine physical examination of the chest and roentgen studies must be made. If the history is suspicious, a lateral roentgenogram of the neck may show a bone or other foreign body. Sometimes it is necessary to follow with a barium capsule or a thin barium meal, to demonstrate a nonopaque foreign body. Children must have roentgen examination from the level of the nasopharynx to the pelvis (figs. 12 and 13).[6]

Complications of Foreign Bodies

In the larynx, edema and stenosis[7] are very serious, often requiring a tracheotomy. Tracheal foreign body may produce emphysema, cyanosis or death. Bronchial obstruction is followed by emphysema, atelectasis, pneumonia, pulmonary abscess or bronchietasis (figs. 14, 15 and 16).

Esophageal foreign bodies may cause dehydration or esophagitis; foreign bodies impacted for long periods may cause ulceration or perforation of the esophagus. A fishbone has been known to cause abscess in the neck or mediastinitis. Other complications of foreign bodies in the air or food passages are pneumothorax and mediastinal emphysema, such as from swallowed glass or other sharp objects.

In several instances, after the removal of a foreign body from the esophagus, a carcinoma or a

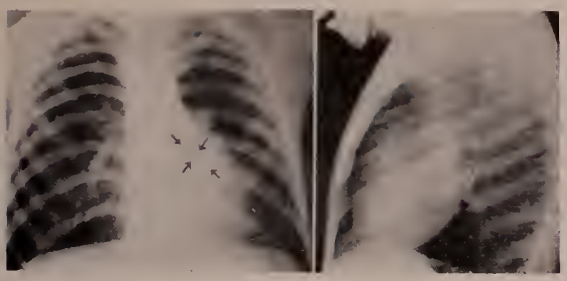


Fig. 13. — Pin in the left main bronchus. The antero-posterior view does not show the foreign body because of the superimposed shadow of the heart; the lateral view is clearcut.

benign cicatricial stenosis has been found. One child had recurring incidents of esophageal foreign body obstruction; a diagnosis of cardiospasm was made. After several dilatations of the esophagus were carried out, the condition cleared up.

Treatment of Foreign Bodies

Foreign bodies in the pharynx, nasopharynx and hypopharynx may often be removed by direct vision or with the aid of a laryngeal mirror. Foreign objects in the larynx, tracheobronchial tree or esophagus require endoscopy. Laryngeal foreign bodies are often very serious, and a tracheotomy may have to precede the endoscopic removal of the foreign body. In esophageal foreign bodies, the object should be removed at once, since complications develop rapidly.

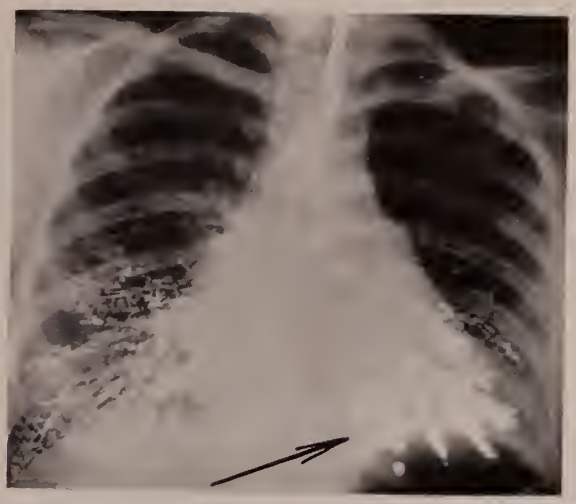


Fig. 15. — Bronchiectasis of the left lower lobe. This often follows an unrecognized foreign body, lodged over a prolonged period. The tracheal catheter for lipiodol instillation is in situ.

The problems of endoscopic removal of foreign bodies from the air and food passages may be briefly outlined as follows:

1. Proper organization and teamwork are essential.
2. Proper instrument selection, including a wide variety of suction tips, bronchoscopes, esophagoscopes and laryngoscopes, in selected sizes for different ages and requirements, must be available. Foreign body forceps which are small enough to go through the bronchoscope and yet sufficiently strong for grasping and removal of



Fig. 14. — Complete atelectasis of the left lung. The heart has shifted toward this diseased side, and the diaphragm is elevated. Such a picture is frequently seen after complete obstruction of a main bronchus by a large foreign body, or an organic foreign body which swells on contact with bronchial secretion as, for example, a bean.

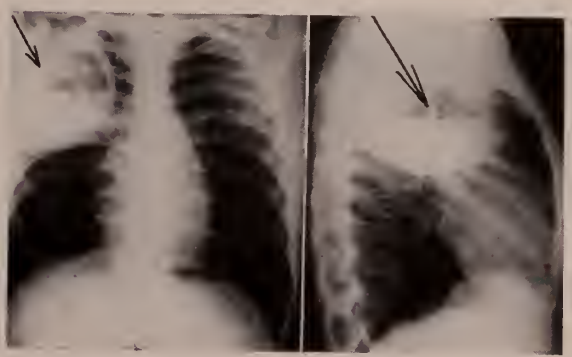


Fig. 16. — Pulmonary abscess of the right upper lobe. The fluid level is plainly shown on the lateral view (right). A complication of complete bronchial obstruction by foreign bodies unrecognized or lodged for prolonged periods.

the foreign bodies are necessary (fig. 17). Endoscopic magnets, for removing certain metallic objects from the respiratory and ailmentary tracts, should be available.[4,8,9]

3. The mechanical problems involved in the seizure, disimpaction, version and removal of the foreign body require specialized knowledge, skill and equipment.



Fig. 17. — Showing the tip of the bronchoscope in the left main bronchus. A forceps extends beyond the bronchoscope and is grasping a foreign body.

Summary

The recognition of the presence of a foreign body by the history and physical and roentgen examinations is discussed.

The clinical picture of a foreign body in the larynx, trachea, bronchi and esophagus is described.

The diagnosis of opaque and nonopaque foreign bodies is not usually difficult; however, the essentials are stressed.

The complications that follow unrecognized and overlooked foreign bodies, which remain for a long period of time, are considered.

A short discussion of the problems involved in the removal of foreign bodies is outlined.

Roentgenograms and other illustrations demonstrating essential facts are included.

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The Program of the

Seventy-Eighth Annual Convention

Hollywood Beach Hotel, April 27-30, 1952

Appears on Pages 630-639

Gynecologic Causes of Pelvic Pain

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PENSACOLA

A commonly accepted idea by members of the laity is that pelvic pain indicates disease of the "female organs." The majority of women seen by the gynecologist seek medical attention because of lower abdominal pain and low backache. In some cases the evaluation of these symptoms is extremely difficult and offers a real challenge to the diagnostic acumen of the physician today.

Before considering gynecologic conditions which cause pelvic pain, it is important to exclude other diseases which may cause this complaint. Guerriero[1] studied 1,197 patients with "gynecological" symptoms, and found that in 502 cases (42 per cent), the complaints were due to nongynecologic causes; 226 patients had urologic disease, 220 patients had orthopedic pathologic conditions, and 60 patients had diseases of the sigmoid and rectum. The investigation of pelvic pain, therefore, may be time-consuming and expensive, but the patient still merits a detailed survey before an exploratory operative procedure or nonindicated drug therapy is employed.

A clearer understanding of the nature of pelvic pain is obtained by studying briefly the general physiology of the pelvic innervation. Mussey and Wilson[2-4] have given a comprehensive review of this subject. The sensory nerves of the pelvic viscera, except those of the ovaries and the distal portions of the tubes, pass through the hypogastric plexus, then by way of the sympathetic nerve trunks to the posterior roots of the spinal nerves. From the posterior roots they pass to the cord and thence to the brain. There are cell stations in the ganglions of the posterior nerve roots. Some painful sensations do not reach consciousness because the impulses are "sorted out" or obstructed in these cell stations. The selective action of these cell stations may be weakened by general systemic disease or nervous exhaustion, and, therefore, a person with such conditions would be more apt to experience pelvic pain. The nerves of the ovaries and distal portions of the tubes course along the ovarian vessels to the aortic plexus. Thus, a presacral neurectomy relieves uterine pain but not ovarian pain.

In many patients the sensation of pain is vague and difficult to localize. This phenomenon is explained by the fact that the viscerosensory fibers are small in size and few in number. Stimuli which produce tension, such as vascular engorgement, edema and inflammation, produce pain. Irritation of the parietal peritoneum produces the most definite type of pelvic pain.

When an investigation of pelvic pain is made, great emphasis is laid upon the initial history. The patient should be questioned carefully concerning the nature of the pain; the association of lower abdominal pain with backache; the exact location of the pain and its severity; whether the pain is constant or irregular; its relation to menstruation; its relation to position, whether worse with standing or lying down; and the duration of the complaint. Attention is given to the other systems of the body — the presence of urinary symptoms or a history of previous disease of the urinary tract; symptoms referable to the rectum or digestive tract; a history of previous disease of the bones or joints.

It is important to question the patient concerning marital or sexual maladjustment and domestic difficulties. A detailed history will serve not only to give the physician an adequate impression of the patient's emotional state, but will give to the patient a confidence and trust in her physician.

Gynecologic Diseases Causing Pelvic Pain

The usual gynecologic diseases which cause pelvic pain are: (1) cervicitis and parametritis, (2) uterine enlargements, (3) pelvic endometriosis, (4) malpositions of the uterus, (5) pelvic congestion, and (6) adnexal disease.

Read at the Northwest Medical District Meeting, Pensacola, Oct. 22, 1951.

Cervicitis is manifested by erosion, hypertrophy, eversion, cystic change and laceration. Parametrial involvement is detected by a thickening of the parametrial tissues on either side and behind the cervix. Pain is reproduced by displacing the cervix to either side or anteriorly with the examining finger. This stretches the parametrial tissues and thus causes pain. Pelvic pain in this condition is believed to be due to the development of a low grade lymphangitis in the parametrial tissues which causes referred pain to the back and lower part of the abdomen.

Enlargements of the uterus cause backache and abdominal pain because of pelvic congestion, and from the stretching of supportive ligaments due to the increased size of the uterus. Enlargements to be considered are uterine tumors, fibrosis and chronic subinvolution, and adenomyosis. Leiomyomas are the commonest tumors and they assume variable sizes. In many cases one is impressed with the fact that large fibroids will not cause significant pain. Fibrosis uteri, chronic subinvolution or adenomyosis is suspected in the slightly enlarged uterus with a somewhat softened consistency. These conditions are usually seen in the multiparous patient.

Endometriosis of the pelvic viscera has a high place in the classification of gynecologic causes of pelvic pain. Gynecologists are becoming more aware of this condition, and the diagnosis is made much more frequently in recent years. The presence of tender, cul-de-sac nodules, a retroverted tender uterus and fixed adnexa in the patient complaining of backache, lower abdominal pain, dysmenorrhea and dyspareunia offers strong evidence that endometriosis is present. The pain is usually worse just before, during, and immediately following menstruation. The examiner must palpate carefully the cul-de-sac to detect the presence of small endometrial transplants. Rectovaginal examination frequently is helpful in discovering them. Pelvic pain from endometriosis results because of fixation of the pelvic structures. There is a vascular engorgement with edema, tension, and scarring of the peritoneum.

Uterine malposition, particularly prolapse, is a frequent cause of lower abdominal pain and backache. In many cases it is most difficult to determine the significance of a retroverted and prolapsed uterus as the cause of the patient's complaints. The explanation of the pain in these cases is a stretching of the supportive uterine ligaments by the prolapsed uterus.. An associated pelvic congestion also results from this malposition. The pain is described as a "pulling," bearing down type of discomfort, worse with standing and relieved upon lying down. Symptoms are usually worse before and during menstruation.

The insertion of a corrective pessary for a period of several weeks still offers a valuable aid in determining the significance of uterine retroversion and prolapse. It is important that the retroverted position of the uterus be corrected before the pessary is inserted. Downward traction on the anterior lip of the cervix with a tenaculum aids in replacing the uterus, and such a maneuver often reproduces the pain of which the patient complains. In typical cases the pain is relieved while the pessary is worn. The symptoms recur when the pessary is removed since the uterus returns to its retroverted and prolapsed position. It should be remembered that in some cases so-called improvement can be attributed to the psychologic effect of wearing the pessary. Current medical literature contains numerous references to the fact that many unnecessary uterine suspensions are performed for uterine retroversion. The prevailing opinion among gynecologists today is that retroversion per se will not cause pelvic pain and that it is the prolapse associated with retroversion which produces symptoms.

Taylor[5,6] amplified the concept of pelvic congestion as a cause of pelvic pain. He described a "congestion-fibrosis" syndrome; pain is caused by vascular and tissue congestion in the pelvic structures. There are arterial dilatation, venous engorgement, and local increases in extravascular tissue fluids. Following the initial congestion phase, a later phase of tissue hypertrophy and fibrosis occurs, as a result of prolonged congestion. Development of such a syndrome is favored by (1) anatomic characteristics of the pelvic veins (unusual dilatability, deficient valves, and weak attachments to surrounding tissues); (2) gravity (upright position increases venous pressure); (3) vascular effects of estrogens (causing salt and fluid storage in the interstitial tissues); (4) circulation changes due to the effect of the autonomic nervous system (vasodilatation caused by local stimuli — psychic stimuli of a sexual nature and psychic stimuli of a nonsexual nature such as worry, anxiety, fear and tension). This author stated that many conditions may cause this syndrome. Malpositions of the pelvic viscera, damaged veins from previous postpartal phlebitis and psychic causes are listed. Such a concept of altered pelvic phy-

siology may explain pelvic pain in many patients in whom an obvious cause cannot be detected.

One of the most important causes of pelvic pain is pathologic change in the adnexa. The conditions to be remembered are inflammation, ovarian cysts, endometriosis, and fixation from previous surgery. The diagnosis of typical pelvic inflammatory disease is rather obvious after an adequate history and careful pelvic examination. The fixed, cystic ovary which results many times from previous plastic surgery of the ovary is a definite cause of lower abdominal pain and backache. Endometriosis may, of course, be confined to the adnexa without involvement of the other pelvic structures. This is illustrated by the "chocolate cyst" described by Sampson. One may see dense adhesions between the adnexa and the adjacent pelvic wall caused by the endometriotic transplants. Prolapsed ovaries may cause pelvic pain. These organs are felt in each side of the cul-de-sac. They are enlarged, of a boggy consistency, and tender to manipulation. The pathologic physiology is that of edema and chronic passive congestion and is not due to inflammation.

A discussion of pelvic pain is not complete without a consideration of the psychosomatic element. This is particularly true in these times when the economic chaos of our society today has so greatly increased the emotional tension of living. This factor as an explanation for pelvic pain must be given major consideration in the so-called "emotional" patient in whom the pelvic disease is believed to be minimal. In such an instance, to attribute the pain to psychic and emotional factors need not be a diagnosis of "resignation." If such a diagnosis were made in particular cases, a great many exploratory pelvic laparotomies would be eliminated.

Treatment

It is the purpose of this presentation to make only brief generalizations concerning the treatment of the conditions which have been listed and not to consider the detailed treatment.

Cervicitis is treated by cauterization, conization, or plastic repair, depending on the extent of involvement. The choice of conization and plastic repair must be made with caution, since cervical stenosis frequently occurs as a result of these procedures. Before the cervix is treated, adequate dilatation should be carried out. Frequent postoperative check-ups are performed; the passage of a uterine sound or a small dilator through the cervix at monthly intervals for at least six months will maintain patency of the cervical canal. The patients should be "selected" with the understanding that they will cooperate and return for check-ups. Except in rare instances, amputation of the cervix has been discarded for two reasons: (1) the incidence of cervical dystocia is high if pregnancy occurs; and (2) the shortened cervix predisposes to the development of chronic endometritis with resulting hypermenorrhea and polymenorrhea. In patients near the menopausal age, in whom the cervical disease is extensive, complete removal of the uterus, by the vaginal or abdominal route, would be the treatment of choice.

Several medical papers have appeared recently in the literature condemning "the cervical stump." The plea is made for complete hysterectomy rather than the subtotal procedure, when removal of the cervix does not add significantly to the technical difficulty of the procedure.

The decision to operate for gynecologic disease and the choice of the procedure to be used must be made with cautious deliberation. Unless the indication for surgery is most definite, it is our practice to see a patient in the office for two or more visits before definitely advising surgery. This allows a substantiation of the original diagnosis and permits a more adequate evaluation of the patient's mental state.

The diagnosis of pelvic endometriosis is not an indication for pelvic surgery. Many of the symptoms caused by this condition can be ameliorated by the use of testosterone. Greenhill[7] recommended 25 mg. of testosterone three times weekly for four weeks; after a rest period of three to four weeks, this therapy is repeated. In the younger patients in whom the symptoms and extent of involvement make surgery necessary, a conservative procedure is followed. The uterus is suspended, the transplants excised, and in many cases a presacral neurectomy is performed. In the older age group, particularly with extensive involvement, the uterus and adnexa are removed. It should be remembered that many patients with endometriosis improve during and following pregnancy.

The surgeon should seek clearcut indications before suspending the retroverted and prolapsed uterus. As was stated, the pessary test offers great help in making the decision as to whether or not surgery should be performed. Most of us agree that the uterine suspension is a greatly "overworked" operation, and it certainly behooves us as surgeons to believe that when we perform this pro-

cedure, we are offering to our patient a fairly good chance that her symptoms will be relieved.

The management of uterine enlargements depends upon the severity of symptoms, the nature of the uterine disease, and the age of the patient. The enlarged uterus which is producing significant symptoms in the woman near or beyond the menopausal age is best treated by complete removal. The emotional sequelae of hysterectomy have been overemphasized by the laity, and many patients in this group are far better off with hysterectomy than with a conservative procedure which may necessitate further surgery at a later time.

In many pathologic conditions of the adnexa a conservative attitude is often rewarded with a definite improvement in the patient's symptoms. The treatment of acute inflammatory disease is nonsurgical, in most cases, and one is frequently amazed at the gradual disappearance of an acutely tender tubo-ovarian mass following antibiotics and chemotherapy.

Many large "simple" ovarian cysts disappear if left alone. Laparotomy is indicated if the ovarian cyst persists or increases in size during an observation period of two months. Ovarian cysts occurring past the menopausal age must be regarded with graver suspicion, and a more radical attitude concerning these is justified.

All gynecologic surgeons should have a thorough knowledge of ovarian physiology.[8] The partial resection of ovaries because of so-called cystic enlargement is followed in many instances by the development of a fixed, pathologically cystic, and poorly functioning ovary. The prolapsed enlarged ovary, which produces symptoms, is often corrected by suspension of the ovary, the utero-ovarian ligament being "reefed" and anchored to the adjacent sides of the fundus uteri.

The patients in those cases which fall into the category of the "congestion-fibrosis" syndrome are best managed by systemic treatment with relief of emotional strain.

The treatment of psychogenic factors which contribute to the development of pelvic pain depends upon the elimination of the cause, if possible. Many of us have seen the anxious and nervous patient, with variable aches and pains referred to the pelvis, become greatly improved when she has been convinced that she does not have pelvic malignant disease nor any serious gynecologic disorder.

Summary

The treatment of pelvic disease may be summarized by saying that every patient should receive a careful evaluation which may require two or more office examinations. The application of set rules of therapy cannot be followed, and each patient must be individualized.

In those conditions which are questionably symptomatic, a policy of "watchful waiting" with constant reassurance to the patient is indicated rather than exploratory laparotomy. The conservative attitude concerning ovarian enlargement should be followed.

Suspension of the uterus should be reserved for those patients who are definitely having symptoms attributed to the uterus and severe enough to justify laparotomy.

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Seventy-Eighth Annual Convention
Florida Medical Association
Hollywood, April 27-30, 1952

The Surgical Treatment of Traumatic Chylothorax by Ligation of the Thoracic Duct; Case Report

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The role of surgery in the treatment of traumatic chylothorax did not assume a position of importance until 1948, when Lampson[1] reported the cure of a case of chylothorax by ligation of the thoracic duct at its lower level within the chest. Prior to this time, medical management alone was practiced in the care of cases of this type, the mortality of such a regimen being nearly 50 per cent.

Chylothorax by definition is an effusion of chyle into the pleural cavity or cavities. Chyle is a thin, milky fluid, alkaline in reaction, and with a specific gravity ranging between 1.012 and 1.021, containing lipoid substances, fibrin and proteins, as well as other constituents of the body fluid. The protein content of chyle in general is about one half that of normal human plasma, usually ranging above 3.0 Gm. per hundred cubic centimeters. Co Tui, Barcham, and Shafiroff[2] have shown that the thoracic duct is an important pathway, not only for the return of proteins from the capillary filtrate to the blood, but also for the mobilization of proteins from protein deposits in the body. Blalock, Robinson, Cunningham and Gray[3] have shown that occlusion of the thoracic duct causes almost complete temporary disappearance of the lymphocytes and eosinophils from the circulating blood. Lampson[1] has shown that chyle is bacteriostatic, hence the rare complication of empyema following chylothorax. Chyle is an irritating substance when introduced into the pleural cavity, producing an inflammatory reaction. Also, the fibrin precipitates out in layers along the pleura and may eventually cause permanent obliteration of the pleural cavity, making re-expansion of the lung impossible unless surgical decortication is performed.

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The thoracic duct begins near the level of the first and second lumbar vertebrae as the cisterna chyli, an oblong dilatation, formed by the junction of the right and left lumbar lymphatic trunks. Davis[4] stated that in 63 per cent of the cases, the thoracic duct is single and passes cephalad into the thorax on the right side of the aorta; at about the level of the fifth thoracic vertebra it crosses over to the left side, entering the posterior mediastinum and ascending behind the arch of the aorta and the left subclavian artery, and eventually empties into the left innominate vein at the junction of the left internal jugular and subclavian veins. Many anatomic variations are possible, and these should be kept in mind when surgery of the duct is considered. It is important to know that the thoracic duct is not infrequently in close relationship to the azygos vein and the great splanchnic nerve in the lower part of the right side of the chest, and that the duct may be injured during sympathectomy.[5]

Etiology

Numerous causes of chylothorax are mentioned in the literature, but only those related to trauma will be included within this paper. Traumatic chylothorax may be caused by any of the varied forms of blunt trauma to the wall of the chest, penetrating wounds of the chest, accident during surgery, falls, hyperextension of the spine, automobile accidents, fractures of the vertebrae, and coughing.[1] Underlying disease may be a predisposing factor.

Diagnosis

The diagnosis is relatively simple and is made by the history of trauma, plus physical findings and roentgenologic evidence suggestive of fluid within a pleural cavity, substantiated by repeated withdrawal of chylelike fluid by thoracentesis. The

immediate symptoms consist primarily of dyspnea, cyanosis and shock of varying degrees, and are caused by mechanical compression of a lung, mediastinal shift, and reduction in vital capacity. If the loss of chyle continues unabated, a rapidly downhill course with loss of weight, weakness, dehydration, protein deficiency, inanition and death is the result.

Treatment

The treatment of traumatic chylothorax resolves itself into two main types: (1) medical, and (2) surgical.

The medical or conservative regimen consists principally of repeated aspirations of chyle from the chest to prevent cardiorespiratory embarrassment, plus measures directed at the maintenance of normal nutrition, including a high protein, high carbohydrate, low fat diet, blood transfusions, intravenous amino acids and glucose, and vitamins, with the hope that the wound of the duct will seal itself spontaneously. It is probably not unwise to administer penicillin or one of the more recent so-called "antibiotics," although the incidence of empyema is low. Human plasma may be given as an adjunct in the correction of the inevitable protein deficiency, but the dangers attendant to the use of pooled human plasma should be borne in mind. Intravenous administration of chyle removed from the chest has been attempted, but sudden death has been reported during such a procedure,[6] and it probably should not be attempted until further experimentation has obviated the likelihood of serious reaction.

Conservative treatment is sufficient for cure in nearly one half of the cases. The remaining 50 per cent terminate in death unless more radical measures are instituted. If it is seen that repeated thoracenteses do not yield a decreasing amount of chyle and that improvement in the general nutritional state of the patient is not occurring, resort to surgery must be made.

There are three practical methods of attack from the standpoint of surgery. The first, and least radical, consists of the closed drainage of the affected pleural cavity by means of a retention catheter inserted into the chest and connected to an under-water air trap, as suggested by Meade, Hood, and Moen.[7] It is their belief that closed drainage should be used for no longer than two weeks, because of the danger of encapsulation of the collapsed lung by fibrin deposits and permanent obliteration of the pleural cavity. The second and third methods have as their goal the permanent elimination of the chylous fistula within the chest, either by intrathoracic ligation of the thoracic duct, as performed successfully for the first time by Lampson[1] in 1946, or by implantation of the lower end of the thoracic duct into the azygos vein, as reported by Hodge and Hunter[5] in 1948. Simple ligation of the thoracic duct is technically much less complicated than implantation of the duct into the azygos vein; hence it is believed that the former is the procedure of choice.

Insufficient time has elapsed since the introduction of these surgical procedures, and because of the paucity of reported cases, an accurate estimation of the morbidity and mortality associated with them is impossible at the present time. The results thus far are encouraging, and prove not only that these measures can be carried out with relative impunity, but also that they are valuable additions to the therapeutic armamentarium in the treatment of a condition which heretofore carried with it a high mortality rate.

Report of Case

H. S. B., a Negro man aged 34, was admitted to Duval Medical Center on Dec. 12, 1949, with a thirty-eight caliber pistol wound of the chest of six hours duration. He complained of slight dyspnea and pain in the back and upper part of the abdomen. The past history and a review of the system revealed little of note with the exception that the patient had poliomyelitis at the age of 8 months, with residual altered gait and slight deformity of the lower extremities.

Physical examination revealed a well developed, well nourished Negro man lying quietly on the emergency room stretcher, exhibiting slight dyspnea but no cyanosis. The blood pressure was 120 systolic and 80 diastolic, the pulse rate 80, respirations 30, and oral temperature 98.6 F. A small perforating wound was noted in the sixth right interspace, at the midclavicular line, there being no wound of exit. The breath sounds were slightly diminished over the base of the right lung, this area also being slightly flat to percussion. Slight tenderness, rebound tenderness, and spasm of the musculature of the upper part of the abdomen were noted.

Initial roentgen examination of the chest and the abdomen was reported as showing "elevation of the right diaphragm with some haziness in the right base, there being a metallic foreign body lying at the level of the eleventh thoracic vertebra, just to the left of the midline, and apparently within the body of the vertebra." Urinalysis gave negative results. The white blood cell count was 15,100, the red blood cell count 4,350,000, and the hemoglobin estimation 11.0 Gm. or 66 per cent. The differential blood count was as follows: lymphocytes 6 per cent, monocytes 1 per cent, stabs 4 per cent, segmented forms 89 per cent, eosinophils and basophils 0.

Thoracentesis was performed on the right side the day after admission, 2,500 cc. of blood being removed. Two days later, 1,500 cc. of blood was removed, and 400,000 units of crystalline penicillin was instilled into the right pleural cavity. Two days later, 3,700 cc. of reddish white, thin fluid was aspirated from the right side of the chest, and forty-eight hours later, another 3,700 cc. of fluid of similar character was withdrawn. Approximately 11,100 cc. of blood and chyle was removed from the right side of the chest during the first week following the accident.

The oral temperature ranged in the proximity of 100 F. during the first week, but gradually declined, occasionally

rising to 99 F. The patient was given parenteral penicillin and streptomycin, intravenous glucose and amino acids, repeated blood transfusions, and a high protein, high caloric, low fat diet, supplemented with vitamins.

Despite these measures, the course was gradually downhill, with increasing weakness and inanition, as well as loss of weight. Repeated thoracenteses were performed, each tap yielding between 700 and 3,400 cc. of milky fluid, no definite decrease in amount being noted. Repeated radiologic examinations of the chest showed no appreciable improvement. Smears and culture of the aspirated fluid were negative, the fluid having a specific gravity of 1.016, a reaction pH of 7.5, and a total protein content of 3.7 Gm. per hundred cubic centimeters. Differential cell count of the fluid showed 84 per cent lymphocytes and 16 per cent neutrophils. The lymphocytes and eosinophils in the circulating blood remained depressed for almost a month after injury, and then gradually returned to their normal values.

On Feb. 1, 1950, almost two and one-half months following injury, under cyclopropane-ether-oxygen endotracheal anesthesia, an exploratory thoracotomy was performed through the ninth right intercostal space by one of us (K. A. M.). The pleural cavity was filled with a yellow-white coagulum which resembled curds. A wound in the thoracic duct was found at the level of the eleventh dorsal vertebra, and a chylelike fluid was seen to be discharging from the defect. Four ounces of heavy cream had been given orally an hour prior to operation in order to increase the fat content of the chyle, and in turn to make the chyle more easily distinguishable.

The defect in the thoracic duct was suture-ligated with no. 00 black silk. Closed drainage of the right side of the chest was instituted during the immediate postoperative period, in addition to parenteral penicillin and streptomycin, plus general supportive measures. During the first two weeks following the operation the right pleural cavity was irrigated daily with Dakin's solution in an attempt to dissolve any clumps of fibrin which might have formed. Several thoracenteses during the early postoperative period produced a small amount of chylelike fluid in gradually decreasing amounts. The patient was discharged on the thirty-third day after operation, roentgen examination at that time showing a small area in the right pleural cavity suggestive of fluid. A small amount of grey-white drainage from the thoracotomy incision persisted for a few days following discharge from the hospital, then ceased spontaneously. At the end of four months, the patient had gained 25 pounds, had no complaints, and roentgen examination of the chest showed no evidence of fluid, there being slight residual roughening of the right dome of the diaphragm and slight blunting of the right costophrenic angle. The right lung was fully expanded.

Summary

A case of chylothorax, due to severance of the thoracic duct by a bullet, with cure by low ligation of the thoracic duct is described.

The causes, diagnosis and methods of management of traumatic chylothorax are discussed, and a brief review of the more recent literature is presented.

Temporary depression of the lymphocyte and the eosinophil counts in the circulating blood was noted following injury to and ligation of the thoracic duct.

Ligation of the thoracic duct should be performed early when it becomes evident that conservative measures are not resulting in improvement of the patient with chylothorax due to trauma.

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238 West Church Street.

President's Address

Seventy-Eighth Annual Convention

First House of Delegates Meeting

Hollywood, Tuesday Morning

April 29, 1952

ABSTRACTS OF MEDICAL ARTICLES

Complete Heart Block in Pregnant Women. By Elwyn Evans, M.D., and Louis Pohlman, M.D. Am. Heart J. 42:18-23 (July) 1951.

The authors present a case in which a second uneventful pregnancy terminated spontaneously in a patient with pre-existing complete heart block, probably congenital; a third pregnancy was interrupted at two months because of increased dyspnea and heart size and definite progressive electrocardiographic changes. They also review the literature and note that only 25 cases of complete heart block in pregnancy, including theirs, have been reported.

Complete heart block, they observe, occurring in pregnancy is not a contraindication to pregnancy; in fact, the patients with this condition do remarkably well. They conclude that termination of pregnancy must be based on the usual indications, not the heart block per se.

Complications Following Pulmonary Resection for Tuberculosis in Streptomycin Treated Patients. By James D. Murphy, M.D., F.C.C.P., Harry E. Walkup, M.D., Hawley H. Seiler, M.D., and S. Bornstein, M.D. Dis. of Chest 19:493 (May) 1951.

An analysis is presented of a series of 22 cases in which bronchopleural fistulas developed following pulmonary resection. This series is compared with a total series of 146 cases of resection in which these 22 cases were included. No remarkable variation was observed except for the higher rate of development of complications in patients with destroyed lungs and those with a substantially exudative or recent component in the pathologic specimen.

The authors conclude that previous treatment with streptomycin decreases the protective power of this antibiotic when it is used as an adjunct to a subsequent resection. This diminution of protective power is more pronounced in patients with resistant than with sensitive organisms. In patients with sensitive organisms, however, the complication rate is higher than in those who are in a virginal state in relation to streptomycin at the time of their resection.

It is noted that similar experiences with resection in streptomycin-protected patients were reported at the Ninth Streptomycin Conference in a series of 630 cases of resection.

Hyperparathyroidism. By H. Milton Rogers, M.D. American Practitioner and Digest of Treatment 2:332-335 (April) 1951.

Noting that parathyroid disturbances are being recognized with increasing frequency, the author observes that recognition of hyperparathyroidism depends upon knowledge of the effect of the parathyroid hormone on calcium and phosphorus metabolism and upon familiarity with the varied clinical manifestations. These manifestations, usually predominantly renal, osseous or gastrointestinal, because of their varying nature are of interest to the internist and general practitioner, also the surgeon, pathologist, orthopedist, urologist, gastroenterologist, ophthalmologist and dentist.

Primary hyperparathyroidism is most commonly due to adenoma of the parathyroid glands, but it may be due to primary hypertrophy and hyperplasia, multiple adenomas, or malignant lesions of the parathyroid glands. The various clinical manifestations and their differential diagnosis are discussed. It is pointed out that diagnosis of hyperparathyroidism depends on familiarity with the renal, osseous, gastrointestinal and chemical manifestations of the disease. Once the diagnosis is established, the treatment is surgical.

Genito - Urinary Tract Infections: Experiences with in Vitro Sensitivity Tests in Choice of Antibiotics. By Joseph C. Hayward, James B. Glanton and Louis M. Orr. J. Urol. 61:-127-131 (July) 1951.

These authors find that cultures with in vitro sensitivity tests on specimens obtained from the genitourinary tract offer an effective adjunct in the management of infections, particularly those of a chronic nature. This regimen eliminates the trial and error use of expensive antibiotics and thus is to be recommended from the standpoint of economy. A practical method of testing organisms for in vitro sensitivity to antibiotics is presented as a means to a more accurate approach to the problem of control and eradication of bacteria in the urinary system. By its use the authors have found it easy to identify the etiologic organism and to give a relatively accurate index as to the antibiotic which will prove most effective in eradicating the infection.

General Practice of Radiology, Chairman's Address. By Joshua C. Dickinson, M.D. J. A. M. A. 147:709-711 (Oct. 20) 1951.

In this particularly able discussion of the general practice of radiology Dr. Dickinson holds the role of the radiologist to be that of a consultant in the fullest sense rather than that of a specialist whose practice is limited to a narrow field. He is also far more interested in the competency of the average general radiologist than in that of the "specialized" specialist whose field of knowledge is becoming more and more restricted. It is his belief that radiology will contribute more to medicine and be of greater service by the continuation of the practice of general radiology than by a division of the specialty into separate fields of diagnostic roentgenology and therapeutic radiology.

Dr. Dickinson deplores the tendency to turn out physicians highly trained in the science of radiology at the expense of inadequate training in the art of clinical medicine. He favors practicing radiology in private offices, with the practice of this specialty in hospitals limited to hospitalized patients, and he sees no insurmountable reason why in hospitals the department of radiology should not be conducted on the same basis as the department of surgery. Regarding the American Board of Radiology and the other specialty boards as the most progressive step in medicine in his lifetime, he nevertheless warns that too often the newly certified diplomate is looked upon as a fully competent consultant in a specialty whereas he is merely qualified to go out and learn to practice his specialty as it applies to the general field of medicine.

Concluding his chairman's address before the Section on Radiology at the One Hundredth Annual Session of the American Medical Association, Dr. Dickinson predicted the future of radiology as follows:

"The future of radiology will be what we radiologists make it. Will we be wise enough to curb the trend toward overspecialization within our ranks? If we are real clinicians and if we practice our specialty better than anyone else can practice it, we do not need to fear that diagnostic roentgenology will be taken over and divided among the various specialties. If, on the other hand, we turn our patients over to the technician, if we are too busy to see patients and maintain the proper patient-physician relationship, if we continue to move our private practice into hospitals where we are subject to every whim and dictate of the hospital administration and boards of directors, then radiology, in my opinion, will cease to be an attractive field that will attract well-trained capable physicians who are interested in clinical medicine."

Congenital Ventricular Septal Defect with Acquired Complete Heart Block. By H. Milton Rogers, M.D., and C. C. Rudolph, M.D. Am. Heart J. 41:770-776 (May) 1951.

In view of the rarity of association of acquired complete heart block with congenital cardiac disease, the authors present the clinical and pathologic observation of a case of congenital ventricular septal defect and acquired complete heart block. The diagnosis of congenital ventricular septal defect was made clinically and confirmed at necropsy. Normal conduction with sinus rhythm was present until the fourth year of life, when complete atrioventricular dissociation and idioventricular rhythm, accompanied by attacks of Adams-Stokes syndrome, developed. Death occurred during one of the Adams-Stokes episodes when the patient was 4½ years of age.

Hospitable Hollywood

The Convention City

Restful, friendly, alluring Hollywood-by-the-Sea, magnetic east coast dream city, will again play host to the Florida Medical Association during its seventy-eighth annual convention. For the fifth time within two decades, the third in succession, Association members and their guests will accept the bountiful hospitality of this popular convention city. Located in a tropical setting, its atmosphere mellowed by cooling ocean breezes, this famed resort approaches the ideal in convention sites.

Founded in 1921 and incorporated in 1925, Hollywood has experienced more than a quarter century of growth and development. Although slowed temporarily time and again by hurricane, depression and war, it has held its own in the terrific competition of the lower east coast.

Convention headquarters will again be the Hollywood Beach Hotel, which justly deserves its reputation as one of the nation's finest resort hotels. It is one of the few establishments of this



Hollywood Beach Hotel — Convention Headquarters for 1952

type in the state large enough and with adequate facilities to house completely and service a convention of this size. The comfort and convenience of the guests are always prime considerations by the management and staff. The numerous shops within the hotel offer a seemingly endless variety of items.

Recreational facilities of the Hollywood Beach Hotel include swimming, tennis, golf and fishing. In addition to the beautiful private beach there is an Olympic size salt water pool. Fishermen may cast their lines into the rolling surf or the relatively quiet waters of the inland waterway. Regularly scheduled trips and boats for charter are available close at hand for those who prefer to do their angling in deep water. The annual handicap golf tournament for members will be held on the hotel course.

Environment and atmosphere play no small part in the success of a convention. The attractions of the Hollywood Beach Hotel, the city of Hollywood and the entire resort area offer additional incentive to doctors and their wives to attend the annual convention. These features will give pleasant support to an outstanding scientific program, which includes a session on scientific motion pictures for the first time, and a greater number of scientific and technical exhibits than ever before. All these attractions bespeak a record attendance and a notably successful meeting.



Hotel Golf Course

★



Beach for Guests



Pool and Cabana Terrace

PROGRAM

of the

Seventy-Eighth Annual Meeting

FLORIDA MEDICAL ASSOCIATION

To be Held at HOLLYWOOD
APRIL 28, 29 and 30, 1952

REGISTRATION

East End of Exhibit Hall

The Registration Desk will be located at the East end of the Exhibit Hall and will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 1:00 p.m. Every member will be required to register and obtain an identification badge before attending any of the sessions. Guests and ladies are required to register at the above designated Registration Desk and obtain their badges.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Pay $3.00 for Smoker privileges at the Registration Desk and obtain your receipt tag which is to be shown at the Cabañas and Pool at 9:00 p.m. Monday and worn throughout the evening.

CONVENTION HEADQUARTERS

Hollywood Beach Hotel

The general headquarters will be the Hollywood Beach Hotel, where the registration desk, assembly room for general sessions, meeting place of the House of Delegates, scientific assemblies, information desk and technical exhibit hall will be located.

The Hollywood Beach Hotel will be headquarters Saturday and Sunday for the 17 specialty groups approved by the Board of Governors.

GOLF

The annual handicap golf tournament for members of the Florida Medical Association will be played at the Hollywood Beach Hotel Links. The tournament will be held Sunday, Monday and Tuesday, April 27, 28, and 29. There will be no Green Fees for members registered at the Hollywood Beach Hotel. Those registered elsewhere will be charged $1.00 per day. Transportation and lockers will be on a free basis.

Those wishing to participate must be registered and show F. M. A. badges.

Rules: U. S. Golf Association, except local rules.

The entrant must register with the starter before beginning his tournament round. Score card must be dated, signed, attested and turned in to the starter at the end of the round. Each player will declare his own handicap.

In addition to the Orlando cup which is awarded annually to the low net scorer, numerous other prizes are being awarded in this year's tournament. An entrance fee of $1.00 is to be paid to Dr. Thomas M. Irwin, Secretary of the Golf Committee. (The last winner of the Orlando Loving Cup, Dr. John C. McKey of Orlando, is requested, on his arrival at the convention, to deliver the cup to Dr. Irwin, Secretary.)

All members who plan to participate please notify Dr. Thomas M. Irwin, Secretary, F. M. A. Golf Committee, 1022 Park Street, Jacksonville.

ANGLERS

Let's go fishing. Adequate sport fishing boats, guides and other facilities will be available. Appropriate prizes will be awarded for the longest, heaviest and smallest catches.

Interested anglers may secure advance information and reservations by writing to Dr. Edgar W. Stephens, Jr., 901 S. Flagler Drive, West Palm Beach, or directly to either the dockmaster at Hollywood or the dockmaster at Dania.

TRAPSHOOTERS

Members interested in trapshooting or skeet are requested to communicate with Dr. Charles F. Henley, Chairman of the Trapshooting Committee, 441 W. Duval Street, Jacksonville, or Dr. Arthur B. Connor, 1547 Rodman Street, Hollywood.

The shoot will consist of 50 targets trap and 50 targets skeet and prizes will be awarded for each. The shoot will be held at the Ft. Lauderdale Gun and Skeet Club, midway between Ft. Lauderdale and Hollywood, just off U. S. highway No. 1.

SMOKER *(Not Stag)*

Monday, 9:00 p.m.

Hollywood Beach Hotel — Cabanas and Pool

The Smoker is always a highlight at each of our State meetings. The Doctors and their wives look forward to a grand evening of entertainment and good fellowship.

This year will be no exception for the Smoker committee is arranging a gala program of events, with a door prize for every lady. The date of Monday night, April 28, is one to remember. Receipt tags for Smoker privileges will be available at the registration desk, Hollywood Beach Hotel for $3 each.

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

Hollywood Beach Hotel — Main Dining Room

Those who are not lodging at the headquarters hotel may obtain dinner tickets ($5.75 per person) from the hotel cashier.

HOTELS

Hollywood Beach — Hotel Headquarters

(American Plan)

Single $17.00 Double $34.00

American Plan rates at the Hollywood Beach Hotel include meals, which are priced as follows:

Breakfast	$1.75
Luncheon	3.50
Dinner	5.75

Persons not lodging at the headquarters hotel may be served meals in the Main Dining Room at the prices quoted. Individual meal tickets sold at cashier's window will include 10% to cover gratuities for those who do not have rooms in the Headquarters Hotel.

For your convenience we have arranged with the hotel management that there shall be no tipping at any meal. A charge of $1.00 per day will be posted to your hotel account to provide gratuities for dining room employees.

OTHER HOTEL ROOMS

Great Southern
(Hollywood Blvd.)

Single Rooms	$ 3.50- 5.00
Double Rooms	$ 7.00- 8.00

Hutchinson
(404 N. 17th Ave.)

Double Rooms	$ 4.00

Royal Palm
(1957 Jackson St.)

Single Rooms	$ 3.00
Double Rooms	$ 4.00

Sheldon
(100 Boardwalk)

Single Rooms	$ 4.00
Double Rooms	$ 5.00

Surf
(300 Boardwalk)

Single Rooms	$ 8.00
Double Rooms	$14.00

MOTELS

Bougainvillea
(1040 S. Federal)

Single Rooms	$ 4.00- 5.00
Double Rooms	$ 5.00- 6.00
Apartments (per day)	$ 8.00-12.00

Dillows
(1831 Plunkett St.)

Single Rooms	$ 3.50
Double Rooms	$ 4.00
One bedroom apartments (weekly)	$35.00-40.00

Filson
(1753 Jackson St.)

Single Rooms	$ 4.00
Double Rooms	$ 5.00

Seaside Manor
(Ocean Dr. — Mich. St.)

Single Rooms	$ 4.00
Double Rooms	$ 5.00

APARTMENTS

Beach and Town
(1010 S. Federal)

Double Rooms	$ 8.50
Efficiency Apartments (daily)	$10.00

Mermaid
(319 Pierce St.)

Efficiency Apartments (daily)	$ 8.00- 9.00

Neptune
(2012 N. Surf Rd.)

Efficiency Apartments (weekly)	$75.00

TECHNICAL EXHIBITS

Technical exhibits will be located in the Great Lounge of the Hollywood Beach Hotel. The technical exhibits have a real scientific value, and physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way. Many exhibitors have nothing to sell, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Hollywood meeting:

Booth	Exhibitor
1.- 2.	Westinghouse X-Ray Division
3.	Organon, Inc.
4.	Tablerock Laboratories
5.	C. B. Fleet Company, Inc.
6.	Schering Corporation
7.	The National Drug Company
8.	Keleket X-Ray of Florida
9.	Ortho Pharmaceutical Corporation
10.	Mead Johnson & Company
11.-12.	The Coca-Cola Company
13.	Burroughs-Wellcome & Co., Inc.
14.-15.	Sealy Company of the Southeast
16.	Chas. Pfizer & Company, Inc.
17.	Carnation Company
18.	A. H. Robins Company, Inc.
19.	The Upjohn Company
20.	White Laboratories, Inc.
21.	E. R. Squibb & Sons
22.-23.	Brayten Pharmaceutical Co.
24.	Lederle Laboratories Division
25.-26.	The Bib Corporation
27.	M & R Laboratories
28.	Philip Morris & Co., Ltd., Inc.
29.	Amedic Surgical Company
30.	J. B. Lippincott Company
31.	Pet Milk Company
32.	The Wm. S. Merrell Co.
33.	Ayerst, McKenna & Harrison
34.	The Nestlé Company, Inc.
35.	Merck & Company, Inc.
36.-37.	Medical Supply Company
38.	Hoffmann-LaRoche, Inc.
39.	Medco Products Company
40.-41.	The Univis Lens Company
42.	Walker Laboratories, Inc.
43.	The Borden Company
44.	Anderson Surgical Supply Co.
45.	General Electric Company, X-Ray Dept.
46.	Abbott Laboratories
47.	A. S. Aloe Company
48.	Surgical Equipment Company
49.	Parco Surgical Supplies
50.	Mercury Medical Company
51.	Blairs Braces, Inc.
52.	H. G. Fischer & Co.
54.	The Baker Laboratories, Inc.
55.	Eli Lilly and Company
56.	Ames Company, Inc.
57.	Sharp and Dohme, Inc.
58.	G. D. Searle & Co.
59.	Sandoz Pharmaceuticals
60.	Ciba Pharmaceutical Products, Inc.
61.	Eisele & Company
65.	Winthrop-Stearns, Inc.
66.	Camel Cigarettes
67.	Park, Davis & Co.
68.	U. S. Vitamin Corporation
A.	J. A. Majors Company

SCIENTIFIC EXHIBITS

The scientific exhibits will be located in the Great Lounge of the headquarters hotel. We consider ourselves fortunate to be able to present for your approval the following exhibits:

B. Public Relations, Florida Medical Association. Eugene B. Maxwell, M.D., Tampa.

C. Cardiac Catheterization: Rheumatic and Congenital. National Children's Cardiac Home, Miami.

D-E. Cytology: Dade County Cancer Institute. J. Ernest Ayre, M.D., Miami.

F. Plastic Surgery of the Nose. Benjamin G. Pollock, M.D., Miami.

G-H. Operative Treatment of Tumors of the Larynx. Nathaniel M. Levin, M.D., Miami

I-J. Bronchiectasis. Leffie M. Carlton, Jr., M.D., Tampa.

K. What is Your Heart Q? George F. Schmitt, Jr., M.D., Miami.

L-M-N. Precancerous Skin Lesions. Wesley W. Wilson, M.D., Tampa.

O-P. Iron Deficiency Anemia — A Dynamic Concept. Sherman R. Kaplan, M.D., Miami Beach, and Steven O. Schwartz, M.D., Chicago.

Q. Neck Resection in Cancer of the Larynx. J. Brown Farrior, M.D., and Richard A. Bagby, M.D., Tampa.

R. Medical Postgraduate Course, Florida Medical Association. Turner Z. Cason, M. D., Jacksonville.

T. Blue Shield of Florida. Leigh F. Robinson, M.D, Fort Lauderdale.

63-64. County Medical Society Displays.

CONVENTION COMMITTEES

SMOKER

Reuben B. Chrisman, Jr., *Chairman*

Francis T. Holland — Lewis T. Corum
Chas. J. Collins — Curtis H. Sory

GOLF

A. Judson Graves, *Chairman*
Thomas M. Irwin, *Secretary*

James T. Shelden — Gustav N. Click
F. Emory Bell — Charles R. Burbacher

ANGLERS

Edgar W. Stephens, Jr., *Chairman*

Scottie J. Wilson — John F. Chapman
George T. F. Rahilly — Frank M. Hewson, Jr.

TRAPSHOOTERS

Charles F. Henley, *Chairman*

Arthur B. Connor — James T. Cowart
Frazier J. Payton — Edward A. Abbey

WOMAN'S AUXILIARY ADVISORY

C. Robert DeArmas, *Chairman*

ASSOCIATION DINNER

Samuel M. Day, *Chairman*

David R. Murphey, Jr. — Robert B. McIver

ALUMNI AND FRATERNITY SUPPERS

Monday, 6:00 p.m.

HOLLYWOOD BEACH HOTEL — DINING ROOMS

EMORY

6:00 p.m. Supper and program
Northeast Dining Room

TULANE

6:00 p.m. Supper on the Ocean Terrace
8:00 p.m. Program in the Theatre, Guest Speaker, M. E. Lapan, M. D.

GEORGIA

6:00 p.m. Supper — Northwest Section
Main Dining Room

OTHER A. AND F. SUPPERS

6:00 p.m. Contact the Dining Room Head Waiter before 5:00 p.m. Monday for reservations in a section of the main dining room and give him the approximate number of plates to be served.

WINNERS OF THE ORLANDO LOVING CUP

The Orlando Loving Cup was donated by the Orange County Medical Society at the Annual Meeting of the Florida Medical Association in 1931 at Orlando.

1931—M. A. Lischkoff, Pensacola
1932—Clarence A. Rudisill, Tampa
1933—Blackburn W. Lowry, Tampa
1934—Hayward J. Blackmon, Tampa
1935—M. A. Lischkoff, Pensacola
1936—Shaler Richardson, Jacksonville
1937—J. R. Chandler, Daytona Beach
1938—William Y. Sayad, West Palm Beach
1939—James T. Cowart, Tampa
1940—Lucien B. Dickerson, Clearwater
1941—William C. Roberts, Panama City
1942—Clarence A. Rudisill, Tampa
1943—No tournament (war)
1944—No tournament (war)
1945—No tournament (war)
1946—Walter C. Jones, Miami
1947—Walter F. Davey, Stuart
1948—Robert D. Harris, Jr., St. Augustine
1949—Dodge D. Mentzer, Lakeland
1950—William G. Meriwether, Plant City
1951—John D. McKey, Orlando

Scientific Motion Pictures will be shown in the Hollywood Beach Hotel Theatre Tuesday morning, April 29, starting at 9 a.m.

MONDAY

FIRST GENERAL SESSION

Monday, 9:30 to 9:45 a.m.

Hollywood Beach Hotel — Sun Room

Call to Order, David R. Murphey, Jr., President

Invocation, The Rev. Harold C. Williamson, Pastor, St. John's Episcopal Church, Hollywood

Address of Welcome, Ralph S. Sappenfield, President, Dade County Medical Association

Announcements

Adjournment

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: James N. Patterson, Chairman, Tampa; James L. Borland, Jacksonville; Carol C. Webb, Pensacola; Frederick K. Herpel, West Palm Beach; Jere W. Annis, Lakeland.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the secretary when read."

"No address or paper before the Association, except those of the president and orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

FIRST SCIENTIFIC ASSEMBLY

Monday, 9:45 a.m. to 12:15 p.m.

Hollywood Beach Hotel — Sun Room

9:45 a.m. "Exchange Transfusion in Erythroblastosis Fetalis" (3¼" x 4" Slides), James J. Griffitts, Miami.
Discussion: Lewis T. Corum, Tampa
Lynn W. Whelchel, Miami

10:15 a.m. "Management of an Outbreak of Anthrax," Scottie J. Wilson, Ft. Lauderdale.

10:45 a.m. "Present Status of Anticoagulant Therapy in Coronary Artery Disease" (3¼" x 4" Slides), E. Sterling Nichol, Miami.
Discussion: Herbert Eichert, Miami
H. Milton Rogers, St. Petersburg

11:15 a.m. "Experiences with the Therapeutic Use of a Long Acting Corticotrophic Preparation" (3¼" x 4" Slides), Carlos P. Lamar, Miami.
Discussion: Sidney Davidson, Lake Worth
Joseph G. Seltzer, Orlando

11:45 a.m. "Salt Depletion Syndrome" (3¼" x 4" Slides), George F. Schmitt, Jr., Miami.
Discussion: Jere W. Annis, Lakeland

SECOND SCIENTIFIC ASSEMBLY

Monday, 2:00 to 4:30 p.m.

Hollywood Beach Hotel — Sun Room

2:00 p.m. "Dermatologic Dangers of Sunlight" (2" x 2" Slides), Morris Waisman, Tampa.
Discussion: Wiley M. Sams, Miami
Lewis Capland, Miami Beach

2:30 p.m. "Coronary Disease of the Inner Ear: The Vascular Origin of Vertigo and Deafness," Jerome A. Hilger, Assistant Clinical Professor of Otology, University of Minnesota Medical School, Minneapolis.

3:00 p.m. "New Method of Feeding the Critical and the Chronically Ill Surgical Patients" (3¼" x 4" Slides), Donald W. Smith, Miami.
Discussion: Capt. Robert M. Lee (MC) USAF, Orlando
Donald F. Marion, Miami

3:30 p.m. "The Use of Artifical Prothesis in the Neck of the Femur" (2" x 2" Slides), Herschel G. Cole, Tampa, and Arthur H. Weiland, Coral Gables.
Discussion: Arthur H. Weiland, Coral Gables
John F. Lovejoy, Jacksonville

4:00 p.m. "Surgery of Parotid Tumors" (2" x 2" Slides), Wilbur C. Sumner, Jacksonville.
Discussion: C. Frank Chunn, Tampa

ALUMNI AND FRATERNITY SUPPERS

Monday, 6:00 p.m.

Hollywood Beach Hotel — Dining Rooms

(See page 632)

SMOKER *(Not Stag)*

Monday, 9:00 p.m.

Hollywood Beach Hotel — Cabanas and Pool

The Smoker is always a highlight at each of our State meetings. The Doctors and their wives look forward to a grand evening of entertainment and good fellowship.

This year will be no exception for the Smoker committee is arranging a gala program of events. The date of Monday night, April 28, is one to remember. Receipt tags for Smoker privileges will be available at the registration desk, Hollywood Beach Hotel for $3 each.

Door prize for every lady — Each lady who obtains a smoker privilege tag will receive a coupon at the registration desk to be presented at the gate of the Cabanas and pool for a door prize.

This year the President will deliver his annual address at the first meeting of the House of Delegates, Tuesday morning, April 29.

TUESDAY

FIRST MEETING HOUSE OF DELEGATES

Tuesday, 9:30 a.m.

HOLLYWOOD BEACH HOTEL — SUN ROOM

Delegates assemble at the Credentials Committee table at entrance of the Sun Room at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee:

Louis M. Orr, II, Chairman
Frederick K. Herpel
Herschel G. Cole

Delegates are to occupy seats in the section designated in order that they may be grouped together. Other members of the Association and guests are requested to occupy seats in another section of the room.

9:30 a.m., President Murphey in the Chair.

Number of eligible Delegates present. Report by Louis M. Orr, II, Chairman, Credentials Committee

Motion to seat Delegates if a quorum is present

Adoption of minutes as published in June 1951 Journal

Gavel to First Vice President, Frederick K. Herpel

President's Address, David R. Murphey, Jr.

President Resumes Chair

Election of one Delegate and one Alternate to A.M.A. House of Delegates for two year terms beginning January 1, 1953

(Terms expiring December 31, 1952 — Delegate, Homer L. Pearson, Jr., Alternate, Frank D. Gray.)

Election of a third Delegate to A.M.A. House of Delegates for two year term beginning January 1, 1953

(Term expiring December 31, 1952 — Delegate, Herbert L. Bryans)

Election of a third Alternate to A.M.A. House of Delegates for remainder of 1952 and for a two year term beginning January 1, 1953.

(A. M. A. By-Laws, Chapter I, Sec. 1: "A member of the House of Delegates must have been a member of the American Medical Association and a Fellow of the Scientific Assembly for at least two years next preceding the session of the House of Delegates at which he is to serve.")

Reference Committee Personnel announced by President

Presentation of Resolutions *(Resolutions not included in House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.)*

Reports of Committee Chairmen:

(To Reference Committee No. 1)

Scientific Work, James N. Patterson
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Frazier J. Payton
Venereal Disease Control, Frank J. Pyle
Tuberculosis and Public Health, Alvin L. Stebbins
Maternal Welfare, E. Frank McCall
Child Health, Egbert V. Anderson

(To Reference Committee No. 2)

Conservation of Vision, R. Renfro Duke
Legislation and Public Policy, Eugene G. Peek, Sr.
Medical Education and Hospitals, Julius C. Davis
Public Relations, Eugene B. Maxwell
Medical Economics, Merritt R. Clements
State Controlled Medical Institutions, William D. Rogers
Representatives to Industrial Council, Charles R. Burbacher
Grievance, Walter C. Payne
Appointment of Medical Examiners, Raymond R. Killinger

(To Reference Committee No. 3)

Board of Governors, David R. Murphey, Jr.
Interrelationship, Henry J. Peavy, Sr.
Necrology, Joseph Halton
Advisory to Woman's Auxiliary, C. Robert DeArmas
Councilor Districts and Council, William C. Roberts
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, James L. Borland

New Business

Announcements

Adjournment

SCIENTIFIC MOTION PICTURES

Tuesday, 9:00 to 11:30 a.m.

HOLLYWOOD BEACH HOTEL — THEATRE

Jere W. Annis, *Moderator*

9:00 a.m. 1. "The Significance of Chronic Hoarsness" (16 mm. film)
2. "Surgery of the Larynx and Trachea" (3¼" x 4" Slides), Nathaniel M. Levin, Miami.

9:40 a.m. "The Commoner Conditions Involving the Esophagus" (16 mm. film and 3¼" x 4" slides), Nathaniel M. Levin, Miami.

10:15 a.m. "Congenital Hip Displasia" (16 mm. film), Theodore Norley, West Palm Beach.

10:35 a.m. "Cataract Extraction by Erisophake" (16 mm. film), James R. Nieder, Delray Beach.

10:55 a.m. "Gastrointestinal Cancer: The Problems of Early Diagnosis" (16 mm. film), Lorenzo L. Parks, Secretary, Florida Cancer Council, Jacksonville.

SECOND GENERAL SESSION

Tuesday, 11:30 a.m.

HOLLYWOOD BEACH HOTEL — SUN ROOM

Call to Order, David R. Murphey, Jr., President

Address (By Invitation), "Pitfalls in the Surgery of the Intervertebral Disk" (3¼" x 4" Slides), William Jason Mixter, Boston

Adjournment

THIRD SCIENTIFIC ASSEMBLY

Tuesday, 2:30 to 5:00 p.m.

HOLLYWOOD BEACH HOTEL — SUN ROOM

Symposium on Hypersplenism
Moderator, Steven O. Schwartz, Director of Hematology, The Hektoen Institute for Medical Research, Cook County Hospital, Chicago.

2:40 p.m. "Hemolytic Anemias" (2" x 2" Slides), Sherman R. Kaplan, Miami Beach.

3:00 p.m. "Thrombocytopenic Purpura" (3¼" x 4" Slides), O. Whitmore Burtner, Miami.

3:20 p.m. "Agranulocytosis and Miscellaneous Manifestations," William W. Trice, Jr., Tampa.

3:40 p.m. "Roentgenologic Diagnosis," J. Maxey Dell, Jr., Gainesville.

3:50 p.m. "Technical Aspects of Splenectomy, Location of Accessory Spleens" (3¼" x 4" Slides), George W. Morse, Pensacola.

4:00 p.m. "Pathology of Hypersplenism," V. Marklin Johnson, West Palm Beach.

4:10 p.m. Summary, Dr. Schwartz
Open discussion

REFERENCE COMMITTEES

Tuesday, 2:30 p.m.

Hollywood Beach Hotel

The three reference committees will meet on Tuesday at 2:30 p.m. in the N. E. Dining Room, S. W. Porch and Men's Card Room. The names of the delegates who have been appointed by President Murphey to serve on reference committees are listed below:

1. HEALTH AND EDUCATION

N. E. DINING ROOM

Edward Jelks, Chairman
Frazier J. Payton
William M. Davis
Jere W. Annis
William H. Walters, Jr.

2. PUBLIC POLICY

S. W. PORCH

Walter C. Jones, Chairman
Eugene G. Peek, Jr.
Donald W. Smith
J. Maxey Dell, Jr.
Hugh G. Reaves

3. FINANCE AND ADMINISTRATION

MEN'S CARD ROOM

William M. Rowlett, Chairman
Shaler Richardson
Franz H. Stewart
William C. Roberts
Duncan T. McEwan

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

Hollywood Beach Hotel — Main Dining Room

Those who are not lodging at the headquarters hotel may obtain dinner tickets ($5.75 per person) from the hotel cashier.

VOUCHERS FOR PRIZES

At Association Dinner

Golf and Other Sports Events

WEDNESDAY

BOARD OF PAST PRESIDENTS

Wednesday, 8:00 a.m.

Hollywood Beach Hotel — Main Dining Room

Julius C. Davis, *Chairman*

Herbert E. White, *Secretary*

Breakfast

Election of a Chairman and Secretary

(According to precedence, William M. Rowlett will succeed the present chairman and David R. Murphey, Jr., the present secretary.)

FOURTH SCIENTIFIC ASSEMBLY

Wednesday, 9:00 to 10:00 a.m.

Hollywood Beach Hotel — Sun Room

9:00 a.m. "Mental Deficiency," William L. Musser, Keystone Heights.
Discussion: Walter W. Sackett, Jr., Miami
Samuel G. Hibbs, Tampa

9:30 a.m. "Pernicious Anemia of Pregnancy" (2" x 2" Slides), Herbert B. Lott, Tampa.
Discussion: Millard B. White, Sarasota
Sherman B. Forbes, Tampa

SECOND MEETING HOUSE OF DELEGATES

Wednesday, 10:30 a.m.

Hollywood Beach Hotel — Sun Room

Delegates sign official attendance cards at 10:00 a.m. at the table of Credentials Committee, Louis M. Orr, II, Chairman, Frederick K. Herpel and Herschel G. Cole located at entrance to the Sun Room.

(No Alternates are to be seated for Delegates attending yesterday's meeting.)

President Murphey in the Chair, 10:30 a.m.

Number of eligible Delegates present. Report by Louis M. Orr, II, Chairman, Credentials Committee

Recommendations of Reference Committees:

No. 1 Health and Education
Edward Jelks, Chairman

No. 2 Public Policy
Walter C. Jones, Chairman

No. 3 Finance and Administration
William M. Rowlett, Chairman

Other unfinished business

Election of Association Officers, 12:00 noon
President-elect
First Vice President
Second Vice President
Third Vice President
Secretary-Treasurer
Editor of The Journal

Dr. Robert B. McIver escorted to the Chair as new President

Presentation of Past President's Button and Certificate of Honor to Dr. David R. Murphey, Jr., by Dr. Robert B. McIver, President

Adjournment

SPECIALTY GROUP MEETINGS

Saturday and Sunday, April 26-27

On July 25, 1948 the Board of Governors ruled that rooms be assigned to the various specialty group societies on Sunday, as heretofore, but that the State Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

FOURTH ANNUAL MEETING
FLORIDA **ALLERGY** SOCIETY

OFFICERS

George F. Hieber, President ..... St. Petersburg
Nelson Zivitz, Vice Pres. & Pres.-elect ..... Miami Beach
James H. Putman, Secy.-Treas. ..... Miami

Sunday, April 27

HOLLYWOOD BEACH HOTEL — SPORTS CENTER

8:00 p.m.
1. "Information Please." General discussion of allergic problems in Florida. Speakers to be announced later.
2. "The Importance of Early Treatment of Childhood Allergy in Modifying and Preventing Allergic Disorders," W. Ambrose McGee, West Palm Beach.
3. "The Use of Terramycin in Viroid Infections of the Allergic Respiratory Tract," Solomon D. Klotz, Orlando.

FOURTH ANNUAL MEETING
FLORIDA SOCIETY OF **ANESTHESIOLOGISTS**

OFFICERS

Harold Carron, President ..... Tampa
John T. Stage, President-elect ..... Jacksonville
R. Gaylord Lewis, Vice President ..... West Palm Beach
Adelbert F. Schirmer, Secy.-Treas. ..... Orlando

Sunday, April 27

HOLLYWOOD BEACH HOTEL — "A" DANCE STUDIO

9:00 a.m. Scientific Meeting
Business Meeting
Election of Officers

SEVENTH ANNUAL MEETING
BLUE SHIELD OF FLORIDA

OFFICERS

Leigh F. Robinson, President ..... Fort Lauderdale
Walter C. Jones, 1st Vice President ..... Miami
Mother Loretto Mary, 2nd Vice President ..... Tampa
Frederick J. Waas, Treasurer ..... Jacksonville
Samuel M. Day, Jr., Asst. Treasurer ..... Jacksonville
Herbert E. White, Secretary ..... St. Augustine

Sunday, April 27

HOLLYWOOD BEACH HOTEL — N. E. DINING ROOM

10:00 a.m. Dr. Robinson presiding

FOURTH ANNUAL MEETING
FLORIDA CHAPTER
AMERICAN COLLEGE OF **CHEST PHYSICIANS**

OFFICERS

Howard K. Edwards, President ..... Miami
Alexander Libow, Vice President ..... Miami Beach
Nathaniel M. Levin, Secy.-Treas. ..... Miami
DeWitt C. Daughtry, Program Chairman ..... Miami

Sunday, April 27

HOLLYWOOD BEACH HOTEL — SUN ROOM

9:30 a.m. Business Meeting
1. "Modern Concepts in the Physiology of Respiration," Alexander Libow, Miami Beach.
2. "Pneumoperitoneum in the Treatment of Emphysema," George L. Baum and Jack Reiss, Coral Gables.
3. "Foreign Bodies in the Larnyx, Bronchi and Esophagus," (slide presentation), Nathaniel M. Levin, Miami.
4. "An Analysis of the Causes for Dyspnoea in Chronic Asthma," Milton B. Cole, St. Petersburg.
5. "Water Soluble Contrast Media for Bronchography," M. Eugene Flipse, Rochester, Minnesota.
6. "Management of the Tuberculous Patient in the Interval Between Diagnosis and Hospitalization," Lester I. Leonard, Lantana.

2:00 p.m. Round Table X-Ray Conference — FLAMINGO ROOM
Common Diseases of the Chest

REGULAR MEETING OF THE FLORIDA ASSOCIATION OF
DERMATOLOGY AND **SYPHILOLOGY**

OFFICERS

Rothwell Lefholz, President ..... Miami
Hollis F. Garrard, Vice President ..... Miami
Morris Waisman, Secy.-Treas. ..... Tampa

Sunday, April 27

Time and place to be announced

SIXTH ANNUAL MEETING
FLORIDA ACADEMY OF **GENERAL PRACTICE**

OFFICERS

Elmer E. Leitner, President ..... Jacksonville
Edward F. Shaver, President-elect ..... Tampa
Raymond R. Killinger, Vice President ..... Jacksonville
L. Paul Foster, Secy.-Treas. ..... Orlando

Sunday, April 27

HOLLYWOOD BEACH HOTEL — THEATRE

7:00 p.m. Scientific Session
Motion picture of the San Francisco meeting of the American Academy of General Practice.
"Intestinal Obstruction," Phillip Thorek, Chicago, Guest Speaker.
Business Session

SEVENTH ANNUAL MEETING FLORIDA **HEALTH OFFICERS'** SOCIETY

Officers

Terry Bird, President ..... Apalachicola
Godfrey L. Beaumont, Vice President ..... Sebring
Lorenzo L. Parks, Secy.-Treas. ..... Jacksonville

Sunday, April 27

Hollywood Beach Hotel — S. W. Porch

2:00 p.m. Scientific Session

1. "Accidentitis in Children," Hugh A. Carithers, Jacksonville.
   Discussion: Frances E. M. Read, Jacksonville.
2. "Typhoid and Other Carriers," William A. Walter, Jacksonville.
   Discussion: Albert V. Hardy, Jacksonville.
3. "Our Midwife Problem," Clarence L. Brumback, West Palm Beach.
   Discussion: Paul W. Hughes, Ft. Lauderdale.
4. "A Report of a Study of Leprosy in Florida," Lucius F. Badger, Medical Director, U.S.P.H.S., Atlanta.
5. "Scientific Critique of Progress in a County Health Unit," Paul W. Hughes, Ft. Lauderdale.
   Discussion: Frank M. Hall, Gainesville.
6. "Recent Advances in Parasitology," Harold W. Brown, Professor of Parasitology and Director, School of Public Health, Columbia University, New York City.
7. "A Study on Medical Indigency Based Upon the State Cancer and Diabetes Control Program," Lorenzo L. Parks, Jacksonville.
   Discussion: Edward R. Smith, Jacksonville.
8. Business Meeting.

THIRTEENTH ANNUAL MEETING FLORIDA ASSOCIATION OF **INDUSTRIAL** AND **RAILWAY SURGEONS**

Officers

Julius C. Davis, President ..... Quincy
John H. Mitchell, President-elect ..... Jacksonville
William G. Harris, Vice President ..... Jacksonville
John H. Mitchell, Secy.-Treas., (pro tem.) ..... Jacksonville

Sunday, April 27

Hollywood Beach Hotel — Theatre

4:30 p.m.

1. President's Address
2. "Use of Intermedullary Pins in Fixation of Fractures," (by invitation), John T. Ellis, Chief Surgeon, Atlanta and St. Andrews Bay Railroad Company, Frasier-Ellis Hospital, Dothan, Ala.
3. "Fractures About the Ankle Dealing Primarily with Pott's Fractures and Their Complications," (by invitation), Lenox D. Baker, Duke University School of Medicine, Department of Surgery, Orthopedic Division, Durham, N. C.
4. Round Table Discussion.
5. Business Meeting and Election of Officers.

SIXTH ANNUAL MEETING FLORIDA SOCIETY OF **NEUROLOGY** AND **PSYCHIATRY**

Officers

Samuel G. Hibbs, President ..... Tampa
W. Tracy Haverfield, Vice President ..... Miami
William H. McCullagh, Secy.-Treas. ..... Jacksonville

Sunday, April 27

Hollywood Beach Hotel — Stock Brokers' Room

4:00 p.m. Scientific Session.

1. "County Responsibiity in Caring for Its Psychotics," Sullivan G. Bedell, Jacksonville.
2. "Neurosurgical Treatment of Hydrocephalus," Robert G. Neill, Orlando.

Business Meeting and Election of Officers.

FIFTH ANNUAL MEETING FLORIDA **OBSTETRIC** AND **GYNECOLOGIC** SOCIETY

Officers

William C. Thomas, Sr., President ..... Gainesville
Dorothy D. Brame, President-elect ..... Orlando
J. Champneys Taylor, Secy.-Treas. ..... Jacksonville

Sunday, April 27

Hollywood Beach Hotel — N. E. Dining Room

2:00 p.m. Business Session — Election of Officers.
Round Table Discussion, Hudnall Ware, Professor of Obstetrics and Gynecology at the Medical College of Virginia, Richmond, leader.

8:00 p.m. Scientific Session.
"Endometriosis in Pregnancy," Hudnall Ware, guest speaker.

THIRTEENTH ANNUAL MEETING FLORIDA SOCIETY OF **OPHTHALMOLOGY** AND **OTOLARYNGOLOGY**

Officers

Charles C. Grace, President ..... St. Augustine
Joseph W. Taylor, Sr., President-elect ..... Tampa
Mozart A. Lischkoff, 1st Vice President ..... Pensacola
G. Tayloe Gwathmey, 2nd Vice President ..... Orlando
Carl S. McLemore, Secy.-Treas. ..... Orlando

Sunday, April 27

Hollywood Beach Hotel — Theatre

10:00 a.m. Scientific Session.

1. President's Address: Charles C. Grace, St. Augustine.
2. "Present Day Management of Chronic Suppurative Otitis Media," Arthur L. Juers, Miami.
   Discussion: J. Brown Farrior, Tampa.
   G. Dekle Taylor, Jacksonville.
3. "Ocular Neuroses," G. Tayloe Gwathmey, Orlando.
   Discussion: Shaler Richardson, Jacksonville.
   Kenneth S. Whitmer, Miami.
4. Business meeting.
5. Annual Report of Florida Council for the Blind, Mr. Harry E. Simmons, Executive Director.
6. Movie — "Cataract Extraction by Erisophake," James R. Nieder, Delray Beach.

2:00 p.m. Scientific Session.

1. "Selection of Operative Procedure in Vertical Muscle Imbalances," Edward A. Dunlap, Associate Professor of Ophthalmology, Cornell University, New York City.
2. "Therapeutic Approaches to the Inner Ear," Jerome A. Hilger, Clinical Assistant Professor of Otology, University of Minnesota School of Medicine, Minneapolis.

Election of Officers

5:30 p.m. Cocktail Party.
Members, wives and guests. (Place to be announced.)

SIXTH ANNUAL MEETING FLORIDA **ORTHOPEDIC** SOCIETY

OFFICERS

Francis W. Glenn, President ..... Miami
Irwin S. Leinbach, Vice President ..... St. Petersburg
Edward W. Cullipher, Secy.-Treas. ..... Miami

Sunday, April 27

HOLLYWOOD BEACH HOTEL — CABANA ROOM

2:30 p.m. Business Meeting
Election of Officers

TENTH ANNUAL MEETING FLORIDA SOCIETY OF **PATHOLOGISTS**

OFFICERS

V. Marklin Johnson, President ..... West Palm Beach
Maxwell M. Sayet, Vice President ..... Miami Beach
Alfred E. Cronkite, Secy.-Treas. ..... Fort Lauderdale

Sunday, April 27

HOLLYWOOD BEACH HOTEL — SAND ROOM

9:00 a.m. General Business Session
Election of New Members
Election of Officers

2:00 p.m. General Session
Technical Problems

FOURTEENTH ANNUAL MEETING FLORIDA **PEDIATRIC** SOCIETY

OFFICERS

Egbert V. Anderson, President ..... Pensacola
Charlotte C. Maguire, President-elect ..... Orlando
J. K. David, Jr., Secy.-Treas. ..... Jacksonville

Sunday, April 27

HOLLYWOOD BEACH HOTEL — MEN'S CARD ROOM

2:00 p.m. Case presentations by members to be selected
Business Meeting

7:00 p.m. Dinner — MAIN DINING ROOM

8:00 p.m. Guest Speaker, Douglas T. Davidson, Director of Epileptic Service of the Neurological Institute of the Children's Medical Center, Boston.

FIFTH ANNUAL MEETING FLORIDA **PROCTOLOGIC** SOCIETY

OFFICERS

Charles E. Hebard, President ..... Tampa
Alexander E. Rosenberg, Vice President ..... Miami Beach
George Williams, Jr., Secy.-Treas. ..... Miami

Sunday, April 27

HOLLYWOOD BEACH HOTEL — "B" DANCE STUDIO

4:00 p.m. Business Meeting — (Fellows Only).
8:00 p.m. Scientific Meeting.
1. "Rectal Bleeding and Factitial Proctitis," Sam N. Sulman, Orlando.
2. "Unusual Perirectal Tumor; Case Report," Frederick E. Farrer, Miami.
3. "Chordoma; Case Report," Alexander E. Rosenberg, Miami Beach
4. "Affections of the Anorectum and Their Management," (by invitation), Harry E. Bacon, Philadelphia.

TWENTY-FIRST ANNUAL SPRING MEETING FLORIDA **RADIOLOGICAL** SOCIETY

OFFICERS

John J. McGuire, President ..... Pensacola
Thomas H. Lipscomb, Vice President ..... Jacksonville
Nelson T. Pearson, Secy.-Treas. ..... Miami

Saturday, April 26

HOLLYWOOD BEACH HOTEL — THEATRE

2:00 p.m. Round Table Discussion — Diagnosis
7:30 p.m. Round Table Discussion — Therapy

Sunday, April 27

HOLLYWOOD BEACH HOTEL — MEN'S CARD ROOM

9:30 a.m. Business Session and Election of Officers

FIFTH ANNUAL MEETING FLORIDA **UROLOGICAL** SOCIETY

OFFICERS

Lee Sharp, President ..... Pensacola
George H. Putnam, President-elect ..... Gainesville
Frank M. Woods, Secy.-Treas. ..... Miami

Sunday, April 27

HOLLYWOOD BEACH HOTEL — SUN ROOM

2:00 p.m.
1. "The Treatment of Hypospadias," Austin Dodson, Richmond, Va.
2. "Pyelographic Clinic," Austin Dodson, Richmond, Moderator.
3. Business Meeting.
4. Election of Officers.
5. Cocktail Party.

"COLLOID BATHS *constitute an essential part of external treatment for many acute and chronic dermatoses"* . . .*

AVEENO...the mild, soothing concentrate from oatmeal provides colloidal protection and emollient relief for irritated and itching skin areas . . . in colloid baths and in local applications.

*"New Type of Colloid Bath" by Kierland & Ede, Rochester, Minn., A.M.A. Arch. of Derm. & Syph., 63,4,502, Apr., 1951.

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TWENTY-FIFTH ANNUAL MEETING

WOMAN'S AUXILIARY

Convention Committee

Mrs. R. F. Stover, *Chairman*

REGISTRATION

East End of the Exhibit Hall

The Registration Desk will be located at the East End of the Exhibit Hall and will be open Sunday, Monday, Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 1:00 p.m. Auxiliary members and guests will be required to register and obtain their identification badges before attending any of the functions. Doctors' wives are invited to attend all of the activities of the Auxiliary.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Pay $3.00 for Smoker privileges at the Registration Desk and obtain your receipt tag which is to be shown at the Cabanas and Pool at 9:00 p.m. Monday and worn throughout the evening.

Door prize for every lady — Each lady who obtains a smoker privilege tag will receive a coupon at the registration desk to be presented at the gate of the Cabanas and pool for a door prize.

ANNUAL PROGRAM

Sunday, April 27

Hollywood Beach Hotel — Ladies' Card Room

2:30 p.m. Executive Board Meetings

Hollywood Beach Hotel — Flamingo Room

8:00 p.m. Reunion hour — A wonderful place to see old friends and meet new and get to know all the Doctors' wives of Florida. A brief round table will be held so that all questions can be asked and answered. While the Doctor is in session come and get acquainted.

Monday, April 28

Hollywood Beach Hotel — Flamingo Room

9:00 a.m. General Auxiliary Session

Hollywood Beach Hotel — N. E. Dining Room

1:00 p.m. Annual Luncheon honoring Mrs. Virgil Eugene Holcombe, President of the Woman's Auxiliary to the Southern Medical Association, Dr. and Mrs. David R. Murphey, Jr., and Dr. and Mrs. Robert B. McIver.

Tuesday, April 29

Hollywood Beach Hotel — Ladies' Card Room

9:00 a.m. Post Convention Executive Board Meeting

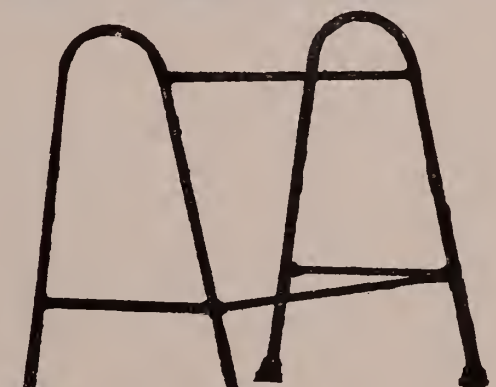
Following the Annual Dinner, Tuesday evening, there will be a gala floor show presented through the courtesy of the Woman's Auxiliary to the Florida Medical Association. Keep your dinner party together and gather at the pool patio for laughter and fun at no extra charge.

Doctor: Will you visit each booth and show your appreciation of the exhibitor's fine cooperation and costly outlay?



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Born in 1880, Dr. William Jason Mixter was graduated from the Massachusetts Institute of Technology in 1902. He was awarded the degree of Doctor of Medicine by the Harvard Medical School in 1906. Since that time he has served on the staff of Massachusetts General Hospital. He organized the Neurosurgical Service there and was Chief of the Service until his retirement from ward service. He has also been a member of the staff of various other hospitals.

During World War I, Dr. Mixter served in the Medical Department of the Army of the United States. During World War II this distinguished neurosurgeon was Senior Civilian Consultant in Neurosurgery, Surgeon General's Office.

The Journal of the
Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION

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Seventy-Eighth Annual Meeting

Luxurious Hollywood Beach Hotel will again completely house the activities of the Florida Medical Association during its seventy-eighth annual meeting, April 28-30. The hotel will provide transportation to its golf course for the members participating in the handicap tournament. The ideally designed Sun Room will be the scene of the two General Sessions, four Scientific Assemblies and the two meetings of the House of Delegates. The complete program is published in preceding pages of this number of The Journal.

This year will see seventeen specialty groups convening during the weekend preceding the opening of the Association's meeting. All groups will hold one or more sessions on Sunday. One specialty society is scheduled for Saturday as well. Each group has been assigned a meeting room of such size as will be adequate for the attendance anticipated. The program for each of these groups appears in this issue.

Dr. James N. Patterson, chairman of the Association's Committee on Scientific Work, together with the members of his committee, Drs. James L. Borland, Carol C. Webb, Frederick K. Herpel and Jere W. Annis, has prepared the program for the scientific assemblies. This year there will be four scientific assembly meetings, one each on Monday forenoon and afternoon and on Tuesday afternoon and Wednesday morning. An innovation this year will be the presentation of scientific motion pictures. This new addition to the scientific program has been scheduled for Tuesday morning in the hotel theatre.

Dr. David R. Murphey, Jr., will deliver his presidential address at the first meeting of the House of Delegates on Tuesday morning. This is a departure from the previous custom of having the presidential address delivered at a general session. An action of the House of Delegates in 1951 directed this change. Also on Tuesday morning just before lunch, the guest speaker, Dr. William Jason Mixter of Boston, will read his paper at the second general session.

Dr. Reuben B. Chrisman, Jr., chairman of the Smoker Committee and the members of his committee, Drs. Francis T. Holland, Lewis T. Corum, Chas. J. Collins and Curtis H. Sory, have completed arrangements for the annual Smoker on Monday night, April 28. This year the Smoker Committee is arranging a gala program of events. Another event of the same evening at 6:00 p.m. will be the Alumni and Fraternity Suppers in the hotel dining rooms.

The annual dinner of the Association is scheduled for Tuesday night at the hotel. In addition to participating in these social events featured annually, the members and their guests will have opportunity for diversified entertainment and recreation which will include golf, trap shooting, ocean and pool bathing, fishing and sea or shore excursions.

The Great Lounge of the hotel overlooking the ocean has been given over to the scientific and technical exhibits. Scientific exhibits will present a wealth of information of value to specialists and general practitioners alike. The numerous technical exhibits will invite careful inspection. Attendants will be on hand at each booth to answer questions on the latest developments in equipment, drugs and other products displayed by the exhibiting firms.

Notice to Delegates and Committee Chairmen

The House of Delegates will hold its first 1952 meeting on Tuesday, April 29, at 9:30 a.m. in the Sun Room of the Hollywood Beach Hotel. The delegates are requested to assemble at the Credentials Committee table at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges. This table will be located at the entrance to the Sun Room. Delegates are to occupy seats in the designated section in order that they may be grouped together. Other members of the Association and guest doctors are requested to occupy seats in another section of the room.

Chairmen of standing committees are urgently requested to be present on time so that their reports may be presented as scheduled in the official program, which is published in this issue of The Journal. Resolutions not included in the House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.

It is highly important that delegates and committee chairmen note the time, the date and the place of this first meeting of the House of Delegates. Register at 9:00 a.m. and convene at 9:30 a.m., Tuesday, April 29, in the Sun Room of the Hollywood Beach Hotel.

The second meeting of the House of Delegates will be held Wednesday, April 30, at 10:30 a.m. Delegates are required to fill out attendance cards for this meeting at 10:00 a.m. at the entrance to the Sun Room. These cards are the delegates' official attendance records. The By-Laws prohibit an alternate from serving for any delegate who was seated at the first meeting of the House.

At 12:00 noon on Wednesday, at this second meeting of the House, the election of officers of the Association for the ensuing year will take place.

Insecticide Residue on Food

DDT, parathion or other insecticide used by the farmer to protect his crops is not a cause of sickness owing to residue on food, widespread rumors to the contrary notwithstanding. After a year's work on chemical additives and their effect on health, the Food Protection Committee of the National Research Council stated recently that no evidence could be found indicating "that consumption of foods resulting from the use of new chemicals in crop production or in the processing of foods has created mysterious diseases and epidemics or endangered the health of the people."[1]

For example, parathion, an extremely poisonous substance, is highly volatile in the form used to control coddling moth on fruit trees. Consequently, it blows away quickly. The farmer is instructed not to use it later than one month before harvest. If he follows directions, the fruit that reaches the consumer will harbor none of the poisonous material.

Also, there need be no uneasiness about chemicals employed to retard mold on bread, improve the quality of evaporated milk and keep butter a summer-yellow all year round. The Council explained that, contrary to circulated reports, the use of chemical additives by reliable food processors has not reduced the nutritional quality of the foods nor created inferior products. Instead, the quality and sanitary characteristics of foods actually have been improving.

1. DDT Not Sickness Cause, Science News Letter 60:386 (Dec. 22) 1951.

This Journal contains the complete program for the Seventy-Eighth Annual Meeting at Hollywood — April 27-30.

The Rugged Individualist's Way of Life

The problems and uncertainties which face the world today seem gigantic and unprecedented. Yet a review of history shows that there have been seemingly insurmountable problems during nearly every generation since the beginning of recorded time.

Now, as ever before, our nation must be strong. In the last analysis, however, a nation can be only as strong as the combined strength of the individuals who make up that nation. Our trusted ally and friend, Great Britain, furnishes eloquent evidence that there can be no guaranteed security for the individual citizen when the government itself is insecure. Social planning by a paternalistic government not only weakens the individual by lessening his incentive to strive and produce, but leads to encroachment upon his freedom and liberty as well.

Resourcefulness, ambition, hard work and rugged individualism are part of the American heritage. Upon examination, it becomes evident that some who have borne the heaviest burdens and have labored most strenuously through the years show less wear and tear than do others who have been sheltered and protected from the blows of unfriendly fortune. Upon further examination, it becomes apparent that physical health, while of great importance, is not the only factor which determines ability to carry on effectively in the face of adversity. Some can bear pain and suffering in such a manner that the ill effects are minimized. Apparently they are able to do so because of better mental attitude and emotional discipline.

Sir William Osler found during his student days a way to chart the course of his life in these words of Thomas Carlyle:

> Our main business is not to see what lies dimly at a distance but to do what lies clearly at hand.

The message contained in that short passage gave young Osler just what he needed to make him the outstanding physician of his era, with character and personal integrity probably not exceeded since that time. Many years later, when in 1913 he was invited to address Yale students, he passed this message on, calling it "A Way of Life." This way of life consisted in living intensely in the present, doing the day's work well and not bothering about tomorrow.

To those who said that this philosophy does not express a satisfactory ideal, Sir William replied from experience, insisting that it does. He had risen from a professorship at McGill to one at Pennsylvania, and then to one at Johns Hopkins where so many of his scientific contributions were made. Finally, he had attained the Regius Professorship at Oxford in 1905, never before held by a British citizen of transatlantic birth.



Sir William Osler

From Cushing: The Life of Sir William Osler, Vol. II, England, Oxford University Press. Photograph by Notman, Montreal.

Sir William pointed out that the margin between mediocrity and greatness is small and he attributed his success to three ideals:

1. Practice of the Golden Rule.

2. Cultivation of a measure of equanimity sufficient to enable him to bear success with humility, the affection of his friends without pride, and grief with the courage befitting a man.

3. Above all, the power of settling down to the day's work and trying to do it well to the best of his ability, letting the future take care of itself.

Physicians can improve their rugged individualism, strengthen their character and create better public relations by living "A Way of Life" in pre-

cept and example. In a farewell message to the profession of Canada and the United States, Osler said, "I have made mistakes, but they have been mistakes of the head not of the heart. I can truly say, and I take upon myself to witness, that in my sojourn among you:-

'I have loved no darkness,
Sophisticated no truth,
Nursed no delusion,
Allowed no fear.'"

Physicians' Civic Responsibilities

"Medicine is a demanding profession. It is also fascinating." This observation comes from no less a personage in American medicine than Dr. John W. Cline of San Francisco, president of the American Medical Association. In his monthly message to A.M.A. members[1] he neatly sums up the duties and responsibilities of medical men as doctors, and as citizens.

Because many doctors become deeply absorbed in their practices they grossly neglect their duties as citizens. At the same time a selfish few outside the profession are not so lax in participation in government activities on local, state and national levels. American medicine has been a convenient and, until recent months, a reasonably docile whipping boy for those who would substitute the down-to-earth American way of life for that of the dream world of the socializers. In the name of security they have attempted to build a wall around the medical profession and its patients.

Dr. Cline believes that it is essential that doctors throughout the country take an aggressive interest in government and citizenship. He warns that this may be the last year there is an opportunity to exercise such rights and privileges unless doctors carry their share of civic duties.

What can doctors do? American medicine's number one man advises: First, to look to medicine's particular responsibility — the health of the people, and second, to answer the call for courageous citizenship. "Now more than ever our profession cannot tolerate the slip-shod doctor or the fee gouger. They must be fearlessly disciplined... We who have chosen medicine as a life's work have dedicated ourselves to the noblest of goals — the welfare of our fellow man. By living up to this goal, we can provide a shining example of free men working skillfully and honestly together to improve conditions of life and doing so without coercion and without regimentation."

1. The President's page, J. A. M. A. 147:1362 (Dec. 1) 1951.

Color Television Milestone

The first transcontinental transmission of color television was a feature of the Los Angeles Clinical Session of the American Medical Association last December. An operation for coarctation of the aorta, performed by Dr. John C. Jones of Los Angeles on a man 20 years of age, was viewed not only at the American Medical Association meeting, where more than 700 physicians were seated before 14 color television receivers, but also at the University of Chicago Medical Center and at the headquarters of the Columbia Broadcasting System in New York City, where medical educators, medical school deans and other physicians were assembled before television receivers. Interestingly enough, Dr. Walter W. Higgs of Park Rapids, Minn., who first diagnosed the lesion in this young man a decade ago, flew to Chicago to watch the operation on his former patient on the television screen at the Chicago Medical Center.

The keen interest manifested by the physicians in the entire color television program made the available space inadequate and was indicative of the role awaiting medical color television in the field of medical education. Each morning members of the staffs of local hospitals presented surgical operations on the color television program, including operations on the gallbladder, thyroid, breast, and bones, and circumcision, hemorrhoidectomy, and the repair of hernia and fistulas. Also shown was childbirth by cesarean section. Clinical demonstrations each afternoon covered treatment of skin diseases, diabetes, cardiovascular diseases, tumors, poliomyelitis, and the care of premature infants. Through a small microphone tucked in his surgical mask, the surgeon described the operation as he proceeded step by step. Originating in the Los Angeles County Hospital, the television signals were relayed seven miles through the air to the Shrine Convention Hall.

The Los Angeles program was the twenty-ninth color television program directed and sponsored by the Smith, Kline, and French Laboratories of Philadelphia at medical meetings throughout the United States, Canada and Europe as a contribution to medical education. The equipment owned and operated by this pharmaceutical firm is especially designed for medical purposes by the Columbia Broadcasting System.

In addition to the color television program, 11 motion pictures were shown once each day. The attendance of 4,149 during the four day meeting

again demonstrated the usefulness of the medical motion picture as a means of postgraduate education. The subjects presented were: the diagnosis of poliomyelitis, self preservation in an atomic attack, the exfoliative cytologic method in the diagnosis of gastric cancer, surgical approaches to the knee joint, physical medicine in the home treatment of arthritis, early diagnosis of uterine cancer, surgical management of primary hyperthyroidism, extraperitoneal cesarean section, the bone bank, operation blood bank, and heparin in the prevention and treatment of thrombosis.

Doctors Commended in Opinion Surveys

Just what does the public think of the medical profession? What does the average citizen see when he pauses long enough to analyze his doctors? Medical societies have spent hard cash for carefully planned public relations programs, directed by experts. Are they paying off? How bad were medicine's relations with the public? How good are they now? Nobody really knew, including the experts, not until recently.

Some interesting views of the public have been brought to light as a result of two scientifically conducted cross-section surveys, held independently in separate, representative communities. One of these surveys was conducted by the Macon County Medical Society in Decatur, Ill.[1] The other was initiated at the suggestion of the Oneida County Medical Society in Utica, N. Y.,[2] but carried out independently.

In both places the average citizen spoke and came forth with remarkably similar observations. He has a fairly high opinion of doctors generally, with an even higher rating for his family physician. He thinks fees for medical services are about right, perhaps a little on the high side. He has little complaint about the quality of medical care, but is more inclined to question hospital charges and facilities, fees for surgery and the cost of drugs.

Percentage figures in the high eighties were recorded on having a family doctor, and being satisfied with him; on being able to get a doctor when needed, regardless of ability to pay and for evidence of the doctor's personal interest in the patient. Equally high in public opinion was courtesy on the part of the personnel of the doctor's office — some added "very," but the amount of time spent in waiting rooms was not so acceptable. Physicians are generally thought to be nice people and good citizens, but even some of those who didn't like doctors still did not want to change them.

About seven out of ten of those questioned carried some form of voluntary health insurance. Most were satisfied with what they had, but only about one-half had ever heard of compulsory health insurance. They were no more familiar with the county society or the A. M. A. Presumably the state association is no better known.

The results of the two surveys point to one of two conclusions. Either medical public relations has been shooting in the dark or it has been far more effective than anyone imagined. Perhaps the medical ear has been too constantly turned to the whining of chronic complainers, the reverberations from real or imagined grievances and the subtle whisperings of those who find it profitable to pan the medical profession.

1. Survey of Opinions of Medical Care in Macon County, J. A. M. A. 147:1363-1366 (Dec. 1) 1951.
2. Know How Your Patients Rate *You?*, Medical Economics 29:66-68 (Dec.) 1951.

Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology

The Florida Society of Ophthalmology and Otolaryngology held its fifth midwinter convention on Jan. 16, 1952 at the San Souci Hotel in Miami Beach. Some 40 members were in attendance and, in addition, several times that many guests from all sections of the country. This meeting is held each year concurrently with the Midwinter Seminar in Ophthalmology and Otolaryngology sponsored by the Department of Medicine of the Graduate School of the University of Florida.

The scientific session was opened at 8 p.m. by Dr. Charles C. Grace of St. Augustine, President, who welcomed the members and distinguished visitors. The first guest speaker was Dr. John M. McLean, Professor of Ophthalmology, Cornell University Medical College, New York City, whose address was entitled "Adrenal Steroid Therapy in Ocular Surgery." The second guest speaker, Dr. Henry L. Williams, Professor of Otolaryngology, Mayo Foundation Graduate School, Rochester, Minn., spoke on "Neurolysis for Hemifacial Spasm" and presented an illustrative motion picture.

As is the custom of the Society, Dr. Grace presented a past president's key to Dr. R. Renfro Duke of Tampa, the immediate past president.

Before the meeting, the Society and the Seminar jointly entertained at the cocktail hour in the Blue Sails Room of the hotel, honoring the many visiting physicians and their wives from across the nation.

This annual midwinter meeting of the Society, held this year for the fifth time, continues to grow in popularity with the members throughout the state. Timed to coincide with the Seminar, it offers exceptional attraction in an ideal setting.

Sixth Midwinter Seminar in Ophthalmology and Otolaryngology

Nationwide interest was manifested again this year in the Sixth Midwinter Seminar in Ophthalmology and Otolaryngology, held at the San Souci Hotel in Miami Beach the week of Jan. 14, 1952. The attendance record attests the widespread popularity of this major feature of the Florida Postgraduate Medical Education program sponsored annually by the Department of Medicine of the Graduate School of the University of Florida. The total registration of 172 represented 34 states, the District of Columbia and 3 foreign countries. The wide geographic distribution is noteworthy:

Florida, 29; Ohio, 21; New York and Pennsylvania, 12 each; Michigan, 10; North Carolina, 7; Illinois, Indiana and Virginia, 6 each; Minnesota, 5; Kansas, Missouri and West Virginia, 4 each; the District of Columbia, Georgia, Iowa, Massachusetts, New Jersey and Tennessee, 3 each; California, Connecticut, Colorado, Mississippi, North Dakota and Wisconsin, 2 each; and Alabama, Arizona, Arkansas, Delaware, Kentucky, New Hampshire, Nebraska, Oregon, South Dakota and Texas, 1 each. The foreign countries represented were Cuba, 1; Canada, 3; and Mexico, 1.

As in previous years, specialists eminent in their respective fields composed the excellent faculty. During the first three days, the lectures on Ophthalmology were presented by Dr. Alson E. Braley, Iowa City, Iowa; Dr. Bruce Fralick, Ann Arbor, Mich.; Dr. Wendell Hughes, Hempstead, N. Y.; Dr. Irving H. Leopold, Philadelphia; and Dr. John M. McLean, New York City. Lecturing the last three days on Otolaryngology were Dr. Fred W. Dixon, Cleveland; Dr. Thomas D. Galloway, Evanston, Ill.; Dr. Anderson G. Hilding, Duluth, Minn.; Dr. Moses H. Lurie, Boston; and Dr. Henry L. Williams, Rochester, Minn.

Held every January for six years in Miami Beach, the Seminar has come to be a welcome midwinter attraction for ophthalmologists and otolaryngologists throughout the entire United States. It offers unexcelled graduate training in delightful surroundings.

Graduate Medical Education

The Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association, the Florida State Board of Health and the Palm Beach County Medical Society will present its annual Diabetes Seminar on March 27-28, 1952 at the Hotel Pennsylvania in West Palm Beach. Dr. Priscilla White and Dr. Howard Root of Boston will deliver the lectures. Dr. White is well known as an authority on diabetes in pregnancy, and Dr. Root, who has been associated with Dr. Elliott P. Joslin for many years, is equally renowned. During the two days, Dr. White will discuss diabetes in pregnancy, in childhood and in youth, diagnosis, hypoglycemia, and insulin and its use, as well as other phases of the subject. Dr. Root in his lectures will cover liver and hemochromatosis, general management with emphasis on diet, surgery and foot lesions, and neuropathy, in addition to other subjects.

On the night of the twenty-seventh, there will be an open meeting to which the public will be invited. The faculty will give brief talks and will answer questions from the floor.

* * * *

Arrangements for the Twentieth Annual Graduate Short Course, to be held at the George Washington Hotel in Jacksonville, June 23-28, 1952, are going forward. It is anticipated that the detailed programs will be available to those in attendance at the annual meeting of the Florida Medical Association in Hollywood, April 27-30, 1952. There is every assurance that the faculty will come up to its usual standards. Dr. Andrew A. Marchetti of the Georgetown University School of Medicine will return as the lecturer on Gynecology, Dr. M. Edward Davis of Chicago will deliver the lectures on Obstetrics, and Dr. Howard Mahorner of New Orleans will present the lectures on Surgery. Other details will be made known to the members of the Association through its local societies and the daily press.

This is the twentieth year this course has been presented to the doctors of Florida. It is hoped

that many of those who have attended in the past years will be present for the lectures this year as well as many new registrants.

* * * *

The Seminar on Diagnosis, to be held just prior to the Short Course, is scheduled for June 19-21, 1952 at the George Washington Hotel in Jacksonville. It will be of special interest to the physicians throughout the state, especially the diagnosticians and internists. Dr. Lewis M. Hurxthal, Dr. Hugh F. Hare and Dr. William Meissner of the Lahey Clinic, Boston, will present the newer aspects of diagnosis with a correlation and interpretation of the subjects the last day of the course. The registration fee will be $25.

YOUR BLUE SHIELD

Doctors Give Information to Blue Shield

More than 1200 doctors have supplied the Florida Blue Shield Plan with informative data about themselves, their practices and their affiliation with the Blue Shield Plan in answer to a special mailing sent to all M. D.'s in the State in the early part of January. Seventy-five per cent of the information was received during the first week after the mailing went out.

Blue Shield is deeply appreciative of the time and effort taken by so many physicians in personally writing their own comments on the information request sheets. A study is now being made of the replies and a more detailed report is being prepared for a subsequent issue of the Journal.*

You might be interested to know that of the physicians who furnished Blue Shield with the requested information

Over 20 per cent said that they would like to have someone from the Plan call on them and answer questions or give information to them and their office nurses.

Over 8 per cent said they would like to be more active in the Plan than they are now.

Almost 100 doctors stated that they would like to be on a public relations committee for Blue Shield in their local county society.

Many doctors requested that they be supplied with informative literature on Blue Cross and Blue Shield and be kept supplied every month.

It is certainly gratifying to Blue Shield to have had this information so willingly and quickly supplied by the doctors of the State and such a fine return of requested information is an indication of the way that physicians are cooperating with the Plan.

Within a very short time Blue Shield will have available its final figures on benefits received by subscribers during 1951. While the exact figures are not known at this time, total Blue Shield payments for 1951 are known to be in excess of $2,000,000. This certainly augurs well for the Plan started by the doctors in 1946 and which, through their cooperation, has consistently shown a rapid rate of growth.

The preliminary information given above on the results of the mailing to all physicians will be supplemented by a report to each county medical society in which the comments and suggestions of the physicians in each particular society will be summarized.

* In case you did not receive a questionnaire from Florida Blue Shield, be sure to write to the Plan at 532 Riverside Avenue, Jacksonville, for the "Personal and Professional Data Sheet." One will be sent to you without delay.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Melvin Newman of Jacksonville announce the birth of a daughter, Allison Marks, on Jan. 15, 1952.

Dr. and Mrs. Mason Romaine, III, of Jacksonville announce the birth of a son, Douglas Patteson, on Jan. 17, 1952.

Dr. and Mrs. Vernon T. Grizzard of Jacksonville announce the birth of a son, Braxton Gale, on Jan. 23, 1952.

Dr. and Mrs. James W. Merritt, Jr., of Miami announce the birth of a son, William Curtis.

Marriages

Dr. Robert C. Welsh of Miami and Miss Cynthia Everett of Indianapolis were recently married.

Deaths — Members

Pitman, James F., Lake City ..... Jan. 31, 1952

Deaths — Other Doctors

Lynn, Isaac W., Desert Hot Springs, Calif. ..... Nov. 16, 1951
Lyncker, Nicolas, Jacksonville ..... Jan. 26, 1952

This Journal contains the complete program for the Seventy-Eighth Annual Meeting at Hollywood — April 27-30.

STATE NEWS ITEMS

The Association was represented at the Fifth Annual Clinical Session of the American Medical Association in Los Angeles, Dec. 4-7, 1951, by delegates, Drs. Homer L. Pearson, Jr., of Miami and Louis M. Orr, II, of Orlando. Dr. Pearson is a member of the Judicial Council and also served as Chairman of the House of Delegates Reference Committee on Medical Military Affairs.

A more detailed report of the Clinical session and the official report of your delegates is contained in the February Journal.

Total registration of Association members at the 1951 Clinical Session was 7. Members in attendance were:

FORT MYERS: Joseph D. Brown. JACKSONVILLE: Joseph L. Chilli. MIAMI: Homer L. Pearson, Jr., Herbert W. Virgin, Jr. ORLANDO: Louis M. Orr, II. PENSACOLA: A. Raymond Haisfield. SARASOTA: Edward F. Meares.

Drs. H. Phillip Hampton of Tampa and Alvin E. Murphy of Palm Beach have been appointed delegates of the Florida Heart Association to the annual General Assembly of the American Heart Association in Cleveland, April 17.

Dr. Herbert L. Bryans of Pensacola spoke at a public meeting of the State Board of Health at the Floridan Hotel in Tampa, January 18.

Dr. Harold B. Canning of Wewahitchka spoke at the regular monthly meeting of the Wewahitchka P.-T.A. on January 10. His subject was "Health Facilities."

Dr. John S. McEwan of Orlando has been named president of the Orlando Utilities Commission. Dr. McEwan had been serving a four-year term as vice president.

Dr. J. Basil Hall of Mount Dora was the principal speaker at a recent meeting of the Groveland Kiwanis Club. Dr. Hall outlined the county health program.

Dr. James V. Freeman of Jacksonville spoke at the January meeting of the Venetia P.-T.A. His subject was "Civil Defense on the Home Front."

Some thirty members of the Association and other interested persons were in Tampa, Sunday, January 27, for a preview of the Association's Fair Exhibit. Present from the headquarters office were Dr. Stewart Thompson, managing director; Ernest Gibson, Norman Ulbright and Tom Jarvis. The exhibit was designed and constructed under the supervision of President David R. Murphey, Jr., and Dr. Eugene B. Maxwell, chairman of the Association's Committee on Public Relations.

Dr. David R. Murphey, Jr., Association president, reports that the initial showing of the Florida Medical Association's Fair Exhibit took place during the Florida State Fair at Tampa February 5-16.

Included in the display was a portrayal of the comparative cost of medical care to that spent for nonessentials. The Exhibit occupied a 45 foot space in the Pan American building. It was staffed by members of the Woman's Auxiliary to the Hillsborough County Medical Association. Blood pressures were taken by teams of student nurses from a Tampa and a St. Petersburg hospital. Blood typing was done under the direction of Dr. James N. Patterson of Tampa.

Dr. Eugene B. Maxwell said the Exhibit would be shown at other fairs at the request of the various county societies. Any society desiring to sponsor a showing at a fair in its locality should contact Dr. Maxwell at Tampa, or the Association's Bureau of Public Relations at Jacksonville.

Dr. Lawrence E. Geeslin of Jacksonville has returned to his practice after attending a graduate course in Philadelphia held under the auspices of the American College of Physicians.

The Florida Tuberculosis and Health Association will hold its annual conference May 15-17 in Daytona Beach. The Florida Trudeau Society will meet in conjunction with the annual conference.

The Fifth American Congress on Obstetrics and Gynecology will be held in Cincinnati, Ohio, March 31 through April 4, 1952, at the Netherland Plaza Hotel. Sponsored by the American Committee on Maternal Welfare, the Congress will feature a comprehensive five-day scientific program covering the medical, nursing and public health aspects of the maternal care team.

Congress registration fees are $5 for members and $10 for non-members. Further information, registration or reservations can be obtained by writing to Mr. Donald F. Richardson, Executive Secretary, American Committee on Maternal Welfare, 116 South Michigan, Chicago 3, Illinois.

Dr. Frederick H. Bowen of Jacksonville presented a paper on "Ligation of the Inferior Vena Cava" at the meeting of the Southern Surgical Association in Hot Springs, Va., in December.

Dr. Saul D. Rotter of West Palm Beach spoke at a recent luncheon meeting of the Civitan Club of that city on recent advances in treating heart disease.

Dr. Elwyn Evans of Orlando was guest speaker at a recent meeting of a local P.-T.A. Along with his lecture, he showed a film entitled, "Guard Your Heart."

Dr. Peritz Scheinberg of Miami presented a paper on "The Effects of Intravenous Papaverine and Procaine on Cerebral Blood Flow and Metabolism" at the January meeting of the Southern Section of the American Federation for Clinical Research.

The Cancer Cytology Center of the Dade County Cancer Institute has announced its second seminar to be held at the Institute in Miami, April 21-25.

In addition to general courses of instruction in cancer diagnosis and cytology, the seminar will also include a conference on carcinoma in situ. Instruction will be under the supervision of Dr. J. Ernest Ayre, director of the Institute.

Registration is limited to 35 physicians. Applications will be accepted through April 19 and should be made to the Dade County Cancer Institute, 1155 N. W. 14th Street, Miami.

Dr. Wesley W. Wilson of Tampa spoke on skin cancer before a recent joint meeting of Tampa civic clubs.

Drs. John D. Milton and Carl H. Davis of Miami addressed a meeting of the South Atlantic Association of Obstetrics and Gynecology at Bellaire, January 24-26.

Dr. Bernard J. McCloskey of Jacksonville spoke at the January meeting of St. Paul's Guild on "Cancer." Three films in behalf of the Blood Bank were also shown. Dr. McCloskey also spoke and showed a film "Operation Blood Bank" at a recent luncheon meeting of the Exchange Club of Jacksonville.

The Second Annual Seminar of the Dade County Pediatric Society will be held at the Jackson Memorial Hospital, Miami, April 23-25, 1952. Registration fee for non-members is $10. For information write Dr. W. S. Nock, 273 Alhambra Circle, Coral Gables.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Clay, Richard C., Miami
DeBusk, Franklin L., Pensacola
Fagan, Harry, Jr., Fort Myers
Greenberger, Isidore M., Miami Beach
Laymon, Russell L., Miami
Miller, Saul, Miami Beach
Nichols, Photis J., Apalachicola
Russell, Lyle W., Miami
Stevens, Charles N., (Col.), Fort Myers
Williams, John S., Dade City

WANTED — FOR SALE

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COMPONENT SOCIETY NOTES

Brevard

At the regular monthly meeting of the Brevard County Medical Society, January 8, in Melbourne, a program was presented by Dr. J. Ernest Ayre of the Dade County Cytology Center.

Broward

New officers of the Broward County Medical Society are Dr. Lloyd U. Lumpkin, Fort Lauderdale, president; Dr. Claus A. Peterson, Fort Lauderdale, president-elect; Dr. Robert J. Patterson, Hollywood, vice president; Dr. William K. Peck, Fort Lauderdale, secretary; and Dr. Julius F. Boettner, Fort Lauderdale, treasurer.

Columbia

Dr. Robert B. Harkness of Lake City was re-elected president of the Columbia County Medical Society at the meeting on January 18. Also re-elected were Dr. Laurie J. Arnold, Jr., vice president; and Dr. Thomas H. Bates, secretary-treasurer, both of Lake City.

Guest speaker for the meeting was Dr. Samuel M. Day of Jacksonville, secretary-treasurer of the Association, who spoke on "Surgery of the Esophagus and Stomach." Included among the other guests were Dr. Stewart Thompson of Jacksonville, managing director, and representatives from the Veterans Administration hospital in Lake City.

Dade

Dr. Selman A. Waksman, discoverer of streptomycin, addressed a special scientific meeting of the Dade County Medical Association on January 31. His subject was "Antibiotics as Chemotherapeutic Agents."

At the regular monthly meeting, February 5, Dr. Peritz Scheinberg of Miami spoke on "The Physiologic Approach to the Treatment of Cerebral Vascular Accidents."

DeSoto-Hardee-Highlands-Glades

At the regular meeting of the DeSoto-Hardee-Highlands-Glades County Medical Society on February 12, Dr. Henry Fuller of Lakeland read a paper on "The Treatment of Some of the Acute Infections."

Duval

The committee on public relations and the publicity committee of the Duval County Medical Society met jointly on January 19 to form a working foundation for the 1952 program. Dr. F. Gordon King heads the public relations committee and Dr. Ralph N. Greene, Jr., the publicity committee. Members of Dr. King's committee present included Dr. Edward C. Watt, Dr. Charles W. Boyd and Dr. George W. Croft. In addition to Dr. Greene, members of the publicity committee attending were Dr. Bernard J. McCloskey and Dr. Marlin C. Moore. Norman J. Ulbright, acting supervisor, and Tom Jarvis, of the Florida Medical Association's Bureau of Public Relations staff, also were present.

At the regular monthly meeting of the Society on February 5, Dr. Perry Volpitto, Professor of Anaesthesia of the University of Georgia, spoke on "Recent Advances in Pediatric Anaesthesia." Preceding the meeting a motion picture, "Clinical Use of Hyaluronidase," was shown.

Hillsborough

At the regular February meeting of the Hillsborough County Medical Association, Dr. Paul L. Rieth of Atlanta spoke on "Disc Syndrome."

Marion

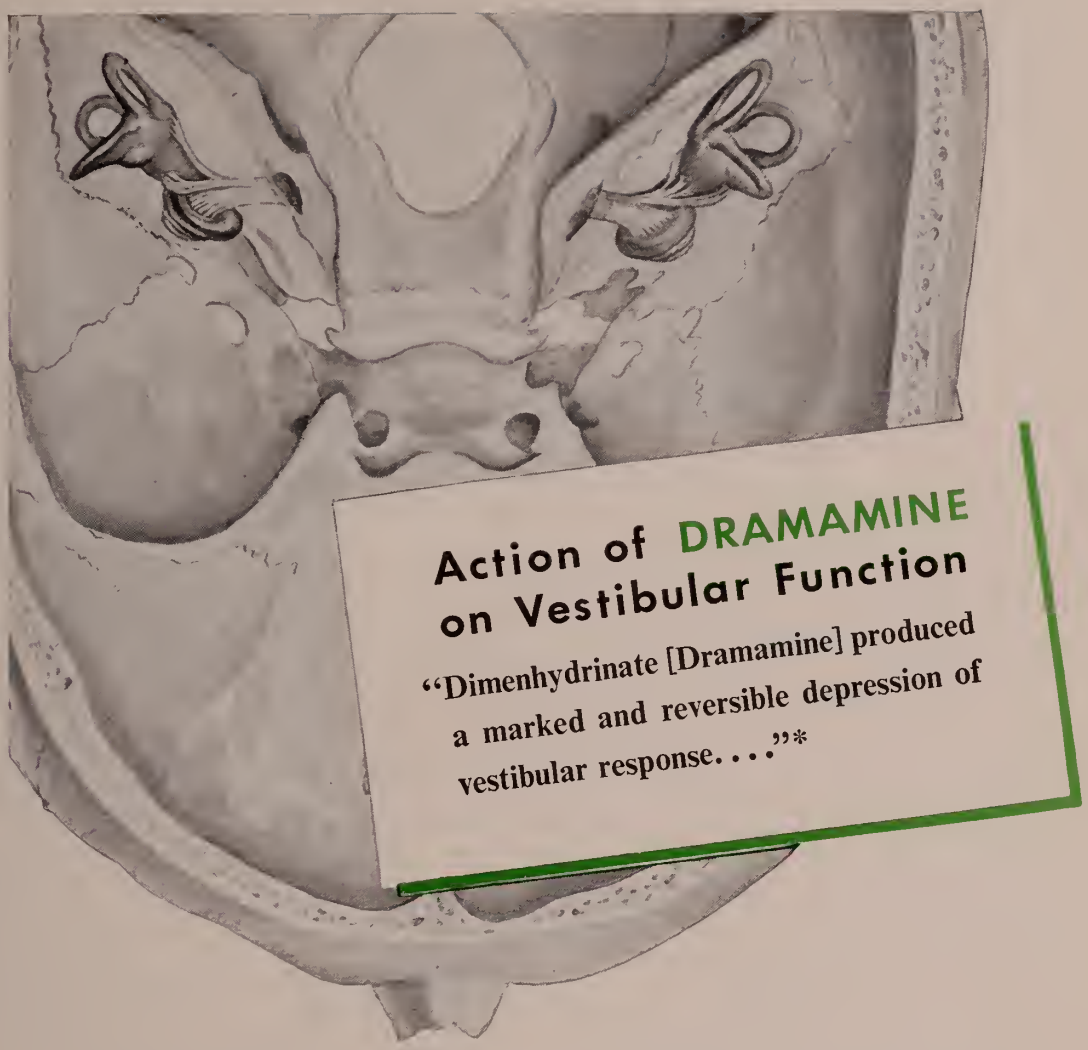
The regular January meeting of the Marion County Medical Society was held with the Woman's Auxiliary. Guest speaker was Dr. Herbert A. King of Daytona Beach who gave a lantern slide illustrated address on the diagnosis and treatment of hematological conditions.

On February 12, the Society met jointly with the Alachua County Medical Society in Gainesville at which time the architect of the proposed medical college at the University of Florida presented drawings of the buildings.

Orange

At the regular monthly meeting of the Orange County Medical Society on January 16, Dr. James D. Moody of Orlando presented a paper on the etiology and physiology of aneurysms and arteriovenous fistulae. The presentation included a motion picture illustrating three types of cases upon which Dr. Moody had operated.

(Continued on page 654)



In a study of the action of Dramamine on vestibular function, Gutner and his associates found that Dramamine "significantly delayed the onset of nystagmus, shortened the duration of nystagmus and increased the milliamperage necessary to effect tilting."

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*Gutner, L. B.; Gould, W. J., and Batterman, R. D.: Action of Dimenhydrinate (Dramamine) and Other Drugs on Vestibular Function, Arch. Otolaryng. *53*:308 (March) 1951.

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(Continued from page 652)

Palm Beach

Dr. Edgar Mayer, professor of clinical medicine, New York University Medical Center, spoke on "Recent Advances in Diagnosis and Treatment of Chronic Pulmonary Diseases," at the January meeting of the Palm Beach County Medical Society.

Pinellas

The weekly Medical Forum of the Pinellas County Medical Society has been so successful that members have decided to present two shows each week divided by a brief intermission. The Forum, designed and executed as part of the Society's public relations program, is scheduled to run through March. At the end of February approximately 40 members had appeared on the Forum and discussed seven medical subjects selected by popular vote through coupons run in the St. Petersburg Times.

At the regular February meeting of the Society, Dr. James M. Stem spoke on "Premature Infants," and Dr. Walter H. Winchester presented an educational movie.

Sarasota

Officers of the Sarasota County Medical Society for 1952 include Dr. Henry G. Morton, president; Dr. Cecil E. Miller, secretary; and Dr. Millard B. White, treasurer, all of Sarasota.

Taylor

Taylor County Medical Society officers for 1952 are Dr. Walter J. Baker, Foley, president; Dr. Mark E. Adams, Perry, vice president; and Dr. Ralph J. Greene, Perry, secretary-treasurer.

Washington-Holmes

All members of the Washington-Holmes County Medical Society have paid their state dues for 1952.

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BOOKS RECEIVED

PDR, Physicians' Desk Reference to Pharmaceutical Specialties and Biologicals, 1952. By J. Morgan Jones, Editor and Publisher. Ed. 6. Pp. 632. Rutherford, N. J., Medical Economics, Inc., 1951.

The sixth edition of PDR (Physicians' Desk Reference —1952) is being distributed free to more than 132,000 physicians in the United States through the courtesy of the manufacturers whose major products, numbering some 1,880, are described in Section Four (White). These products are classified by pharmacologic designation, drug or chemical group in Section Two (Yellow), and by therapeutic indications in Section Three (Blue). Section One (Pink) contains an alphabetical index of brands and manufacturers of over 5,000 pharmaceutic specialties and biologic products. General professional information is presented in Section Five (Green). This excellent index for quick reference purposes is produced and distributed annually to keep pace with the changes in formulas and the appearance of new drugs and new specialty products.

The Battle for Mental Health. By James Clark Moloney, M.D. Pp. 105. Price, $3.50. New York, Philosophical Library, 1952.

An eminent American psychoanalyst here sets forth a grim warning of the rapid increase in mental illness in the United States and offers constructive suggestions for bringing about sound mental health. To current obstetric, pediatric and child-rearing methods he attributes the lion's share of responsibility for mental illness. He compares today's regimented handling of children with the warmly permissive practices of the so-called "primitives," and shows which of the latter's technics can be effectively transplanted to this country, without, however, advocating a wholesale substitution of primitive for civilized life. Dr. Moloney clearly and forcefully presents the urgent need for promoting relaxation in American mothers and for the exchange of Cornelian Corner (rooming-in) procedures for present day maternity methods. He amply supports his theories with scientific clinical, anthropologic and experimental observations.

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From where I sit *by* Joe Marsh

It Isn't the Heat— It's the Hide!

Big discussion after the Grange meeting Friday night. Tik Anderson said that hogs were more affected by the hot weather than cattle. Skeeter Morgan declared that it wasn't so—that he *never* saw any hogs bothered by the hot sun like his cows were.

I was glad when Rusty Robinson stepped in.

"Boys," he says, "don't get so riled up. It all depends on what *color* the livestock are. Hogs or cattle, those with light-colored coats absorb less heat from the sun than animals with dark coats. You're *both* right!"

From where I sit, so many useless arguments could be avoided if a person would remember he doesn't have all the right on his side. Like those who would tell others how to practice their profession—like those who would insist that coffee, for instance, is the only drink, forgetting that other people have a right to a glass of beer now and then. If we wouldn't get so "het up" about our prejudices—we'd all be better off!

Joe Marsh

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OBITUARIES

Baldwin Shields Stutts

Dr. Baldwin Shields Stutts of Dunnellon died on Dec. 27, 1951 in Williston at the home of his son-in-law and daughter, Mr. and Mrs. Charles Tullis. He was 63 years of age.

The son of Aaron Baldwin and Mamie Shields Stutts, Dr. Stutts was born in Thomasville, Ala., in 1888. He was awarded the degree of Doctor of Medicine by the Medical College of Alabama in 1909. During World War I he served in France and held the rank of captain.

Dr. Stutts located in Florida and engaged in the practice of medicine for some years in Milton. In 1927 he moved to Dunnellon, where he continued to practice until forced into retirement two years ago owing to declining health. Locally, he was a member of the Wall-Rives American Legion Post No. 58.

Highly esteemed by his professional associates, Dr. Stutts was a past president of the Marion County Medical Society. He was also for many years a member of the Florida Medical Association and the American Medical Association.

Dr. Stutts was married in 1913 to Miss Ellie Bobe of Jacksonville, who survives him. Other survivors include one son, Baldwin S. Stutts, Jr., of Clearwater; two daughters, Mrs. Warren Decker of Seneca Falls, N. Y., and Mrs. Tullis; and five grandsons.

Louis Burgh Mount

Dr. Louis Burgh Mount of St. Petersburg died at the Mound Park Hospital in that city on Dec. 10, 1951. He was 71 years of age.

A native of Troy, N. Y., Dr. Mount was born in 1880. He received his Master's degree from Cornell University in 1901 and the degree of Doctor of Medicine from the Medical College of that institution in 1905. Following graduation, he studied dermatology in the European medical centers of Heidelberg and Vienna. Upon his return, he located in Albany, N. Y., where he practiced the specialty of dermatology for twenty-six years and concurrently served on the faculty of Albany Medical College. During World War I, he served his country as a captain in the Medical Corps.

Sixteen years ago Dr. Mount located in St. Petersburg, where he continued to be actively engaged in dermatologic practice until the time of his death. Locally, he was a Mason and a Shriner, and was a member of the Temple Beth-El.

A member of the Pinellas County Medical Society, Dr. Mount was also a member of the Florida Medical Association and the American Medical Association. He was an honorary member of the Manhattan Dermatological Association and a diplomate of the American Board of Dermatology.

Surviving are the widow, Mrs. Rose B. Mount, and one daughter, Miss Charlotte Mount, both of St. Petersburg.



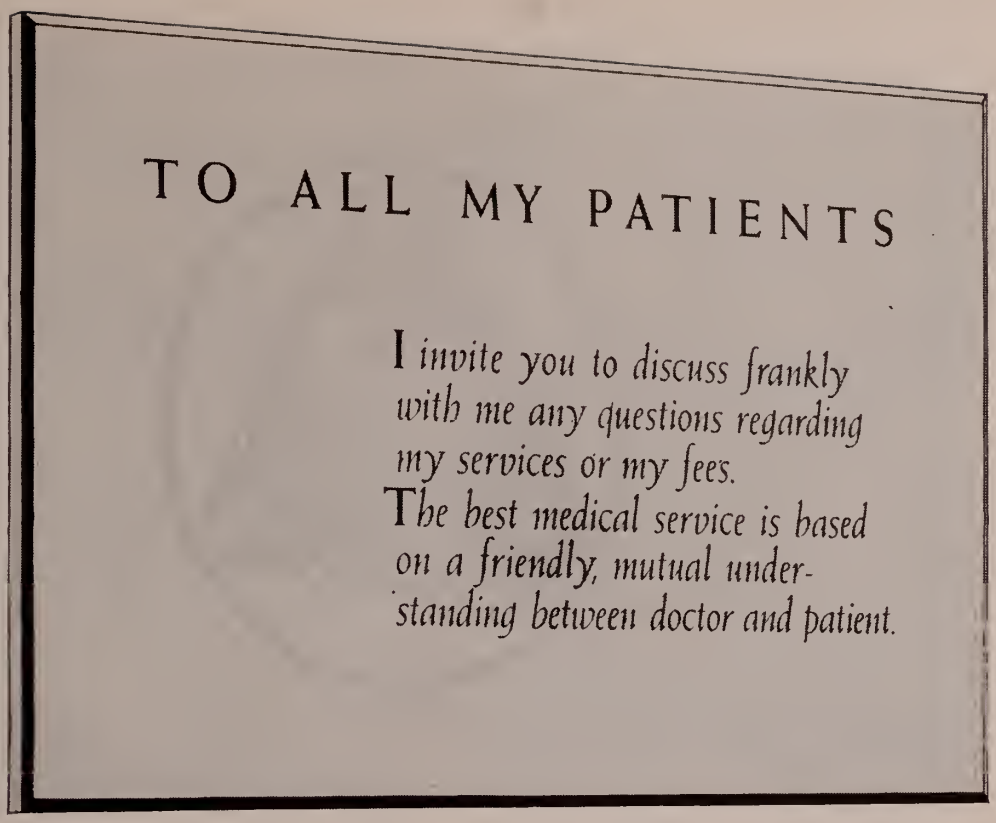
MIAMI MEDICAL CENTER

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1861 N. W. South River Drive
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A private institution for the treatment of nervous and mental disorders and the problems of drug addiction and alcoholic habituation. Modern diagnostic and treatment procedures — Psychotherapy, Insulin, Electroshock, Hydrotherapy, Diathermy and Physiotherapy when indicated. Adequate facilities for recreation and out-door activities.

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mutual understanding

to the best medical service

Yes, doctor, the best medical service is based on friendly, mutual understanding between doctor and patient. To help you create better public relations, the American Medical Association is making available—as a service to its members—an attractive new plaque to be displayed on an office desk or wall. This plaque will open the door to better relations with your patients because it encourages questions regarding professional services and fees. Price is one dollar—order yours today. Fill out the coupon and send to *order department*

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Therapy for Vascular Headache to Reverse the Physiologic Disturbance

Headache, a problem encountered in all kinds of medical practice, may occur in association with any of a variety of disorders, some organic, other purely functional.

Among the several types, functional headaches present the greatest problem because of their obscure etiology and recurrent nature.

Among these are:

Migraine (both classical and variant forms)
Tension headache
Psychogenic headache
Histaminic cephalgia

Wolff and his co-workers established that the pain of these headches is due to disturbance of the tonus of cranial blood vessels — hence the term *vascular headaches.*

The craniovascular changes associated with the several phases of the typical migraine attack are:

Vasoconstriction — to which the visual prodromata are attributable. It is possible to abort the attack during this phase in all but a few cases. (See treatment below.)

Vasodilatation — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

Vessel Edema — if the vasodilation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

Therapy: 1. Reduce the frequency of attacks — psychotherapy and regulation of living habits to avoid fatigue and nervous tension.

2. Relieve the acute attack — of the numerous drugs which have been tried, ergotamine and its derivative preparations have proved most effective. The newest product is oral tablets of Cafergot®, N. N. R. (ergotamine with caffeine 'Sandoz'). When dosage is adjusted to the needs of the individual, Cafergot will give good relief in 85% of cases. It enables a greater number of patients to benefit from early administration since the oral route simplifies treatment as compared to parenteral therapy.

The dosage procedure is:

1. Take 2 tablets at first sign of the attack.
2. If attack continues, take one additional tablet every ½ hour until attack is terminated *(max. 6 tabs. per attack).*

Many migraine patients delay taking medication until the attack is at its height. Explicit dosage instructions may be forgotten unless the patient comes to realize their importance. Therefore, to encourage adherence to correct procedure, we have prepared pads outlining detailed dosage instructions. Supplies of these INSTRUCTION SLIPS will gladly be sent upon request.

GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull *54:* 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Wolff, H.: Headache and Other Head Pain, N. Y., Oxford Univ. Press, 1948.

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, N. Y.

WOMAN'S AUXILIARY
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Auxiliary Trend

The increasing membership in local auxiliaries as well as the formation of new ones reveals a healthy trend in thought direction among Florida doctors' wives. A cognizance of Auxiliary potential which is giving impetus to its growth was manifested wherever I visited this year. A sense of dignity prevailed at every meeting and an earnest desire to function effectively was evident. The cause is obvious.

New growth has replaced dead timber and the indifferent mind and vacillating personalities have been outnumbered by the vigorous leadership found in vital county presidents and executive groups who realize that they can accomplish a great deal by combining their energies and directing this force toward a public good.

In this organization, a thousand women have learned what public relations in a doctor's family really means.

They have become aware of the threat which at first seemed to be directed at the medical profession, but revealed itself to be a deterioration of our whole social system, and have learned how to combat it.

Ambulance Service
FERGUSON FUNERAL HOME
H. E. Ferguson, Licensed Director
1201 South Olive
WEST PALM BEACH, FLA.

They have, through the study group program, learned that organization is the vehicle which when properly run can carry valuable cargo into needed areas. It is also a depot, the source of request and supply. It is a central place to which information can be sent; to which Civil Defense, Red Cross, Blood Bank and all community health leaders can appeal for voluntary workers.

They have learned it is many faceted in activities and interest, primarily concerned with promoting the health and welfare of the community as well as preserving the best attitudes in that community through education.

Because we believe in good will, and work toward fostering friendship throughout Florida among physicians' families, a friendliness has developed.

Because we are organized to further the doctor's aims we became better acquainted with his aims and take pride in preserving his ideals. In this, as in all things, we are active in proportion to the importance we attach to the principles involved.

Our membership will continue to grow, for the integrity of the motive determines the quality as well as quantity of the membership since people gravitate toward the things in which they believe and are willing to serve.

Mrs. C. Robert DeArmas, President

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting March 3, March 17, March 31. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 3, June 2. Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 17, June 16. Surgery of Colon & Rectum, One Week, starting March 3, April 7. Personal Course in General Surgery, Two Weeks, starting April 14. Gallbladder Surgery, Ten Hours, starting April 21. Basic Principles in General Surgery, Two Weeks, starting March 31. Breast & Thyroid Surgery, One Week, starting June 23. Esophageal Surgery, One Week, starting June 23. Thoracic Surgery, One Week, starting June 2. Fractures & Traumatic Surgery, Two weeks, starting June 16.

GYNECOLOGY—Intensive Course, Two Weeks, starting March 17, April 21. Vaginal Approach to Pelvic Surgery, One Week, starting March 31, May 5.

OBSTETRICS—Intensive Course, Two Weeks, starting March 31, June 2.

PEDIATRICS—Intensive Course, Two Weeks, starting April 7. Informal Clinical Course, every two weeks. Cerebral Palsy, Two Weeks, starting July 7.

MEDICINE—Intensive General Course, Two Weeks, starting May 5. Electrocardiography & Heart Disease, Two Weeks, starting March 17. Gastroenterology, Two Weeks, starting May 19. Hematology, One Week, starting June 16. Gastroscopy & Gastroenterology, One Week Advanced Course, starting June 23.

UROLOGY—Intensive Course, Two Weeks, starting April 28. Ten Day Practical Course in Cystoscopy, starting March 17, March 31, April 14.

DERMATOLOGY—Intensive Course, Two Weeks, starting May 5.

Teaching Faculty:
Attending Staff of Cook County Hospital

Address: Registrar, 707 South Wood Street, Chicago 12, Illinois

The Brook Haven Manor Sanitarium announces the opening of its annex for the reception of geriatric patients and the elderly.

Brook Haven Manor Sanitarium
Stone Mountain, Georgia

Suburb of Atlanta, Georgia

THE TECHNICAL EXHIBIT

One feature that always adds materially to the success of an annual meeting is the technical exhibit. Every firm represented in the display features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

WESTINGHOUSE ELECTRIC CORP., X-RAY DIVISION — 1-2

Westinghouse will exhibit their new Westex table for use in Radiographic and Fluoroscopic techniques. This table is designed with an intimate knowledge of the needs and budgets of private practices, clinics, and hospitals. This table has many new features, such as motor tilt, single or two tube arrangement, headrest, counterbalanced tubearm, and full-table-length bucky travel. The other items that will be featured are the fulorothin illuminator and color transparencies. Westinghouse representatives from Jacksonville, Miami and Tampa will be present to answer any questions on application of our equipment.

ORGANON, INC. — 3

Organon will feature two new products representing real advances in liver therapy and steroid therapy. The first product to be featured is Pernaemon, a new painless liver injection. The other product is Stenediol, a new protein-building steroid which is free from the marked virilizing effects of the male hormone. Further information, literature, and samples of these two products will be available at the booth.

TABLEROCK LABORATORIES, INC — 4

Your Professional Service Representative, Mr. Harry Brown, cordially invites you to visit the Tablerock exhibit. Literature, samples and information will be available on our well established ethical pharmaceutical specialties, such as Bismuth Violet, Bufosal, Cithal and Flanithin, as well as the new "daytime" sedative, Taborea. Your visit to our booth will be most appreciated.

C. B. FLEET COMPANY, INC — 5

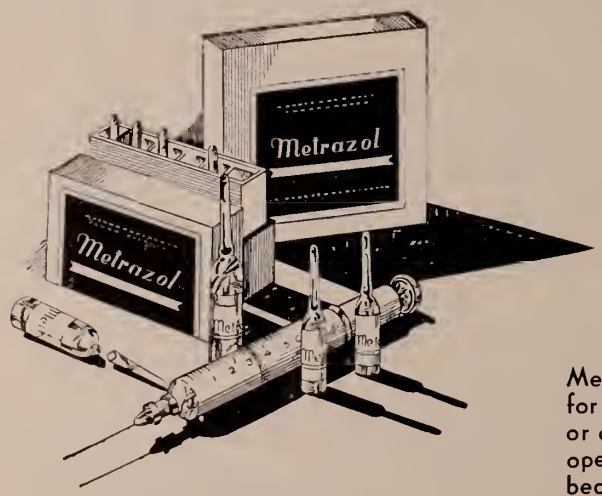
SCHERING CORPORATION — 6

Members of the Florida Medical Association and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured. Included in this exhibit will be Prantal, Methylsulfate, Schering, the first selective anticholinergic agent and Dormison, the non barbiturate hypnotic. Schering representatives will be present to discuss with you these products as well as other products of our manufacture.

THE NATIONAL DRUG COMPANY — 7

The National Drug Company, pioneer in the clini-application of resin therapy, will feature Resion, an intestinal adsorbent; Resinat, a polyamine exchange resin for the treatment of peptic ulcer; and Natrinil, a cation exchange resin for the control of edema. Trained representatives will be in attendance to discuss our resin preparations and other specialties: ACTH, Ammivin, AVC Improved, Benat, DTP Vaccine, Natolone, as well as any of National's vast array of pharmaceutical and biological products.

KELEKET X-RAY OF FLORIDA — 8



Metrazol, pentamethylentetrazol
Ampules, 1 cc. and 3 cc.
Sterile Solution, 30 cc. vials
Tablets and Powder

Metrazol

COUNCIL ACCEPTED

A DEPENDABLE, QUICK-ACTING CEREBRAL AND MEDULLARY STIMULANT

Metrazol is indicated for narcotic depression, for instance, in poisoning with barbiturates or opiates, in acute alcoholism and during the operation and postoperatively when respiration becomes inadequate because of medullary depression due to the anesthetic.

Inject 3 cc. Metrazol intravenously, repeat if necessary, and continue with 1 or 2 cc. intramuscularly as required.

Bilhuber-Knoll Corp. Orange, N. J.

Ortho Pharmaceutical Corporation — 9

Ortho cordially invites members of the Association and their guests to their exhibit. The Ortho display this year will consist of the Ortho line of obstetrical and gynecological specialties, including Triple Sulfa Cream, Dienestrol Cream, and Aci-jel for vaginal infections. A new product, Nutri-Discs for the treatment of infertility, will be featured.

Mead Johnson & Company — 10

Mead Johnson & Company, Evansville, Indiana, will feature Lactum and Dalactum, convenient formulas of evaporated milk containing Dextri-Maltose; three water-solube vitamin preparations, Poly-Vi-Sol, Tri-Vi-Sol and Ce-Vi-Sol; Fer-In-Sol, a palatable, highly concentrated solution of ferrous sulfate. Also Mulcin, a pleasingly flavored vitamin emulsion, for teaspoonful dosage, as well as four Pablum cereals, including Barley and Rice. Representatives in attendance will be glad to furnish information regarding the above products.

The Coca-Cola Company — 11-12

Burroughs Wellcome & Co., Inc. — 13

"Aerosporin" brand Polymyxin B Sulfate, a new antibiotic, effective against Pseudomonas aeruginosa, destroys most other gram-negative bacilli. "Polysporin" brand Polymyxin B — Bacitracin Ointment, broad spectrum for all pyogenic infections including External ear infections, Styes, Acne, Furuncles; rarely sensitizes — resistance rarely develops.

Sealy Company of the Southeast — 14-15

Sealy will again feature the Firm-O-Rest Posturepedic mattress and foundation — the ideal adjuvant to backache therapy. It provides a flat bed with no sag, acts as a firm splint to the back, yet affords maximum comfort. The Junior Posturepedic mattress and foundation, designed especially for young people between the ages of 4 and 16 years is shown for the first time.

Chas. Pfizer & Co., Inc. — 16

Terramycin, newest of the broad-spectrum antibiotics forms a dramatic central feature of the display of Chas. Pfizer & Co., Inc., Brooklyn, N. Y. The newest dosage forms of Terramycin are exhibited and indications for use are described.

Carnation Company — 17

You are invited to visit our booth where you will see an attractive display on Carnation Evaporated Milk — "The Milk Every Doctor Knows." Some valuable information on the use of this milk for infant feeding, child feeding and general diet will be explained and the reasons why Carnation Milk deserves consideration as your first choice for infant formulas. Interesting and valuable literature will also be available for you.

(Continued on page 662)

HIGHLAND HOSPITAL, INC.



FOUNDED IN 1904

Asheville, North Carolina

AFFILIATED WITH DUKE UNIVERSITY

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures—insulin, electroshock, psychotherapy, occupational and recreational therapy—for nervous and mental disorders.

The Hospital is located in a sixty-acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. CHARMAN CARROLL, M.D.,
Diplomate in Psychiatry
Medical Director

ROBT. L. CRAIG, M.D.,
Diplomate in Neurology and Psychiatry
Associate Director

(Continued from page 661)

A. H. ROBINS COMPANY, INC. — 18

The A. H. Robins Company exhibit is featuring Phenaphen and Phenaphen with Codeine, "the complete analgesics"; and Entozgme, the "tablet-within-a-tablet" for comprehensive digestive therapy. Robins' Medical Service Representatives welcome the privilege of discussing with physicians attending the Assembly these and other products in the company's line of prescription specialties.

THE UPJOHN COMPANY — 19

It is the sincere desire of The Upjohn Company to make some definite contributions to the success of the 1952 meeting. Stop by our booth to relax and discuss topics of mutual interest.

WHITE LABORATORIES, INC. — 20

Dienestrol, the potent, orally effective synthetic estrogen, will be on display. Dienestrol differs chemically from stilbestrol and other synthetic estrogens. It is unique in its action and is one of the best tolerated of all oraly effective synthetic estrogens.

E. R. SQUIBB & SONS — 21

BRAYTEN PHARMACEUTICAL CO. — 22-23

LEDERLE LABORATORIES DIVISION — 24

You are cordially invited to visit our exhibit, where you will find representatives who are prepared to give you the latest information on Lederle products.

THE BIB CORPORATION — 25-26

The Bib Corporation will be exhibiting an exact scale model of our canning plant. This exhibit has over 1,000 working parts and required two months of work to complete. This exhibit will show how Bib is processed from the time oranges are brought to the plant from the grove, until the cans have been labeled, cased and loaded in the freight car for shipment. Also, the Bib Corporation will introduce, to the medical profession, for the first time the new Bib Juices for Babies. The new Bib juices are Bib Prune-Orange Juice and Bib Orange-Apricot. Samples of these two new Baby Juices will be presented, along with informative literature, to every Doctor visiting our booth.

M & R LABORATORIES — 27

M & R Laboratories, Columbus, Ohio. Our representatives for Similac and Cerevim will be most happy to discuss with you the merits and use of our products in the field of infant and child nutrition.

PHILIP MORRIS AND CO., LTD., INC. — 28

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These results show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

AMEDIC SURGICAL COMPANY — 29

You, who want to see the newest models in surgical instruments, Burdick Electrocardiograph, and Diathermy, visit our booth.

J. B. LIPPINCOTT COMPANY — 30

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

From Our

WESTBROOK PORTFOLIO

A private psychiatric sanatorium employing modern diagnostic and treatment procedures—electro shock, insulin, psychotherapy, occupational and recreational therapy—for nervous and mental disorders and problems of addiction.





This view of the Administration Building is typical of the restful beauty of the Westbrook 125-acre estate.

WESTBROOK SANATORIUM

Staff: PAUL V. ANDERSON, M.D., President; REX BLANKINSHIP, M.D., Medical Director; JOHN R. SAUNDERS, M.D., Associate; THOMAS F. COATES, M.D., Associate

P. O. Box 1514 RICHMOND, VIRGINIA Phone 5-3245

Pet Milk Company — 31

Specially trained representatives will be in attendance to discuss the use of Pet Milk in infant feeding, and to present many services that are time-savers for busy physicians. Miniature Pet Milk cans will be given to visitors at the exhibit.

The Wm. S. Merrell Company — 32

The prompt, effective and comfortable relaxation of gastrointestinal smooth muscle spasm Merrell presents Bentyl Hydrochloride. Bentyl is a high milligram potency non-narcotic antispasmodic with two-fold musculotropic and neurotropic action. Effective therapeutically without atropine-like side actions in functional gastrointestinal disorders. Bentyl is particularly suited for prolonged administration without habituation or increased tolerance.

Ayerst, McKenna & Harrison — 33

Physicians attending the Florida Medical Association Convention are cordially invited to visit the Ayerst booth. Our representatives will be happy to answer your inquiries relative to Premarin, Mediatric, Clusivol or other Ayerst specialties.

The Nestlé Company — 34

You are cordially invited to visit Nestlé's booth, where specially qualified representatives will be on hand to answer your questions on any of Nestlé's milk products — already best known and most used for babies 'round the world. New pieces of valuable professional literature will be available.

Merck & Company, Inc. — 35

Medical Supply Company — 36-37

Hoffmann-Laroche, Inc. — 38

Roche will feature Gantrisin, the more soluble sulfonamide which has a wider antibacterial spectrum. Gantrisin is highly effective in the treatment of systemic and urinary tract infections. Stop at the Roche booth where members of the field staff will be glad to discuss this more effective and better tolerated sulfonamide.

Medco Products Company — 39

Univis Lens Company — 40-41

Among the items of interest to be featured at the display of the Univis Lens Company will be multifocal lenses, fitting devices and manufacturing processes. Univis products such as the Univis improved type bifocals, Univis Continuous Vision Lenses and other lenses of the Complete Multifocal Service and their importance to patients' visual comfort will be shown.

Walker Laboratories, Inc. — 42

Precalcin, the complete prenatal product supplying all essential vitamins and minerals will be exhibited. Precalcin is unique in that the capsules contain a dry powder fill with no fish liver oils, thereby providing excellent tolerance and patient appeal. Other outstanding preparations will also be featured and our representatives present will be glad to discuss all aspects of current therapy in their particular fields.

(Continued on page 664)



Allen's Invalid Home

MILLEDGEVILLE, GA.
Established 1890
For the treatment of
NERVOUS AND MENTAL DISEASES

Grounds 600 Acres
Buildings Brick Fireproof
Comfortable Convenient
Site High and Healthful

E. W. Allen, M.D., *Department for Men*
H. D. Allen, M.D., *Department for Women*
Terms Reasonable



BRAWNER'S SANITARIUM
Established 1910

SMYRNA, GEORGIA
(Suburb of Atlanta)

For Nervous and Mental Disorders
Drug and Alcohol Addiction
Electro-Shock in selected cases

JAMES N. BRAWNER, M.D. Medical Director
ALBERT F. BRAWNER, M.D. Department for Men
JAMES N. BRAWNER, JR., M.D., Department for Women

(Continued from page 663)

The Borden Company — 43

Meet Bremil, conforming to the pattern of human milk; Mull-soy for your milk-allergic patients; Dryco, with its formula flexibility; Biolac a liquid modified milk for infant feeding; Beta Lactose, the improved milk sugar; Klim powdered whole milk; and the Special Protein and Lactic Acid Milks. Borden men are pleasant men!

Anderson Surgical Supply Co. — 44

General Electric Company X-Ray Dept. — 45

The X-Ray Department of the General Electric Company will display a number of interesting products, including the new Hand Stereoscope. Mr. Frank R. Arrington, Jacksonville; Mr. Louie L. Clasen, Tampa; and Mr. Richard A. Steinheimer, Miami, will be on duty at their exhibit throughout the Meeting, and they extend a cordial invitation to everyone in attendance to visit the General Electric exhibit.

Abbott Laboratories — 46

Abbott will present an animated exhibit on Desoxyn Hydrochloride (Methamphetamine Hydrochloride, Abbott) showing the use of the product in the management of certain cases of obesity. In the cast of characters are a green snake Temptation and a wavering dieter. Desoxyn, in addition to curbing the appetite, imparts a feeling of well-being and increases mental and physical activity.

A. S. Aloe Company — 47

Surgical Equipment Company — 48

Parco Surgical Supplies — 49

Mercury Medical Company — 50

Blairs Braces, Inc. — 51

H. G. Fischer & Co. — 52

Inspect H. G. Fischer & Co.'s modern, efficient, low priced x-ray and physical therapy equipment. Let their representatives point out many features of advantage in these units and other models not on display. Your visit welcome — No obligation.

The Baker Laboratories, Inc. — 54

Baker's Modified Milk (Powder and Liquid) and Varamel (Liquid) are especially made, from Grade A milk (U. S. Public Health Service Milk Code), for the bottle fed baby. Both are modified by the replacement of the milk fat with animal and vegetable fats and with the addition of vitamins and iron. Baker's is completely prepared and only water needs to be added. Varamel is the new formula base to which carbohydrate and water are added in accordance with the needs of the infant.

Eli Lilly and Company — 55

Your Lilly medical service representative cordially invites you to visit the Lilly exhibit. Featured will be a demonstration of functional packaging as an aid to medical practice. Modern manufacturing departments will be illustrated. Literature on new therapeutic developments will be available.

Ames Company, Inc. — 56

The Ames Diagnostic Kit will be featured. This small kit, measuring 3 x 9 inches, contains Clinitest — a test for urine-sugar, Bumintest — a test for albumin, Acetest — a test for acetone, and Hematest — a test for occult blood. No extra reagents, equipment, or accessories are needed. This kit is designed for the physician's office, small laboratory, hospital floor use, etc. The Ames representatives will be demonstrating these tests. Ames Company representatives will be glad to discuss Decholin and Decholin Sodium, the standard hydrocholeretic agents for the treatment of biliary tract disease.

TUCKER HOSPITAL, INC.

212 West Franklin Street

Richmond, Virginia

A private hospital accepting for diagnosis and treatment organic neurological conditions, selected psychiatric and alcoholic cases, metabolic disturbances of an endocrine nature, individuals who are having difficulty with their personality adjustments, and children with behavior problems. Patients with general medical disorders admitted for treatment under our staff of visiting physicians.

Under the Professional Charge of

Dr. Howard R. Masters,

Dr. James Asa Shield and Associates

Sharp & Dohme, Inc. — 57

Research data relative to the potentiating effect of the antibiotics, bacitracin and tyrothricin, are featured in the Sharp & Dohme booth. The synergistic effect of penicillin in conjunction with the sulfonamides and clinical data on the use of Vitamin B12 are also of major interest. Our representatives will welcome your visit.

G. D. Searle & Co. — 58

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Banthine, the true anticholinergic drug for the treatment of peptic ulcers; Dramamine, for the prevention and active treatment of motion sickness; and Alidase, Searle brand of hyaluronidase which permits subcutaneous feedings at intravenous speed. Other time proven products of Searle Research on which information may be obtained are Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine, and Pavatrine with Phenobarbital.

Sandoz Pharmaceuticals — 59

It is with a great deal of pleasure and pride that we invite you to visit our scientific exhibit at our booth. Our Florida representative, Mr. Elbert McLaury, Jr., will gladly welcome you.

Ciba Pharmaceutical Products, Inc. — 60

Ciba Pharmaceutical Products, Inc., Summit, New Jersey, invites you to visit its exhibit which will feature Pyribenzamine in the treatment of drug dermatoses, showing the action of this effective antihistaminic when absorbed through damaged skin and by oral administration. Representatives in attendance will be glad to answer questions about Pyribenzamine and other Ciba products.

Eisele & Company — 61

Winthrop-Stearns, Inc. — 65

Winthrop-Stearns, Inc., New York, invite you to visit their booth, where the following products will be featured — Milibis, new, virtually non-toxic chemotherapeutic agent for the treatment of intestinal amebiasis; Aralen, effective antimalarial, also specific for extra-intestinal (hepatic) amebiasis; Levophed, the true vasoconstrictor hormone of the adrenal medulla, for the maintenance of blood pressure in shock and other acute hypotensive states; Mucilose Compound Tablets, the new physiologic bulk laxative.

Camel Cigarettes — 66

Parke, Davis & Company — 67

Medical Service Members of the Parke, Davis & Company Staff will be in daily attendance at our Commercial Exhibit for consultation and discussion of the various Products listed in our Pharmaceutic, Antibiotic, and Biologic Catalog. Important Specialties, such as Chloromycetin, Penicillin S-R, Benadryl, Vitamins, Oxycel, Thrombin Topical, Hypnotics, and others will be featured. You are most cordially invited to visit our Exhibit with the assurance that your personal interest will indeed be very much appreciated.

U. S. Vitamin Corporation — 68

See the "oil-in-water" demonstration of liposoluble vitamins A and D made completely water soluble . . . a vitamin technical achievement originated and developed by the U. S. Vitamin Corporation Research laboratories. Three pharmaceutical firsts . . . Vi-syneral Vitamin Drops — multivitamins in drops solution; Vi-Syneral Injectable — multivitamin parenteral solution and now Vi-Aqua Therapeutic — aqueous multivitamins in capsules . . . for more rapid absorption, greater therapeutic activity, shorter treatment time. We cordially invite you to our booth for detailed literature and professional samples.

J. A. Majors Company — A

The W. B. Saunders Company, Medical Publishers, will be represented by their Southern Agents, J. A. Majors Company. Visiting doctors will find on display late books such as "Surgical Practice of the Lahey Clinic"; Cecil, "Specialties in General Practice"; Wechsler, "Clinical Neurology," 7th edition; Callander-Anson & Maddox's "Surgical Anatomy," 3rd ed.; Kroger, "Psychosomatic Gynecology," and many others.

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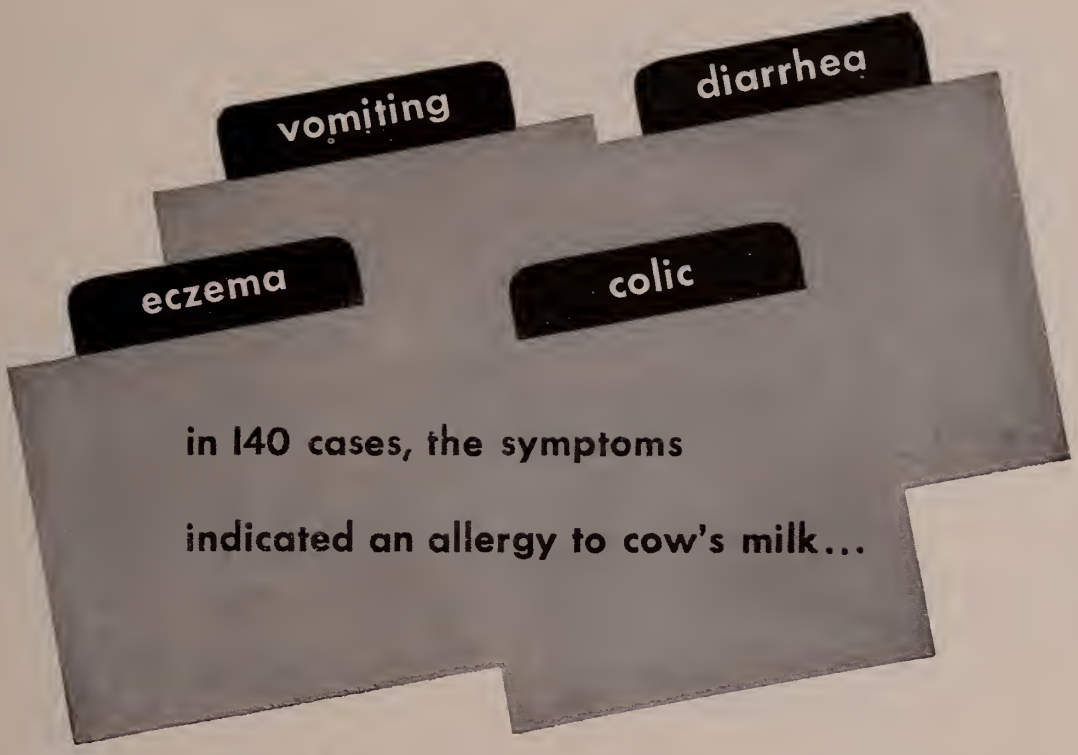
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*Clein, Norman W.: Cow's Milk Allergy in Infants, Ann. Allergy 9:195 (March-April) 1951.

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Meat and its Important Contribution of Essential Minerals

With the exception of calcium and iodine,[1] meat, as customarily consumed, makes an important contribution to the mineral needs of the American people. Its minerals include those needed in substantial amounts as well as those needed in trace amounts only.

The array of data listed below gives the approximate amounts of essential minerals provided by muscle meat when seven ounces per day are consumed.[1] The minerals include those now known to be essential components of the human organism—the skeletal framework and teeth, soft tissue structures including blood, and substances concerned in regulatory functions.

APPROXIMATE MINERAL CONTENT OF MEATS

200 Gm. (approx. 7 oz.),[1] Edible Portion (Uncooked)

	Beef Round	Lamb Leg	Pork Loin	Veal Shoulder
Minerals, total[2]	2.0 Gm.	1.8 Gm.	1.8 Gm.	2.0 Gm.
Calcium[2]	22 mg.	20 mg.	20 mg.	22 mg.
Chlorine[3]	147 mg.	136 mg.	125 mg.	147 mg.
Copper[3]	0.2 mg.	0.2 mg.	0.2 mg.	0.2 mg.
*Iodine[4] (Ohio animals)	0.02 mg.	0.03 mg.	Data not available	0.01 mg.
Iron[2]	5.8 mg.	5.4 mg.	5.0 mg.	5.8 mg.
Magnesium[3]	46 mg.	42 mg.	39 mg.	46 mg.
Phosphorus[2]	360 mg.	426 mg.	372 mg.	398 mg.
Potassium[3]	661 mg.	610 mg.	559 mg.	661 mg.
Sodium[3]	164 mg.	152 mg.	139 mg.	164 mg.
†Cobalt[5]	0.0002 mg.	———	Data not yet available	———
†Manganese[3]	0.03 mg.	0.03 mg.	0.02 mg.	0.03 mg.
†Zinc[5]	9.4 mg.	———	Data not yet available	———

*Iodine content of meat varies with the iodine content of feed of the animals.
†Needed in trace amounts only.

The average values for iron, phosphorus, and copper of the four kinds of meat shown constitute about 46, 25, and 100 per cent, respectively, of the National Research Council's recommended daily allowances for adults, and the average values for chlorine, potassium, and sodium constitute about 14, 63, and 16 per cent, respectively, of the estimated daily adult needs, as based on mineral balance studies.[6] Although no specific information is available on the quantitative needs for cobalt, magnesium, manganese, and zinc, nutrition information would suggest that the amounts reported above have nutritional importance or significance.

In addition to its notable content of essential minerals, meat also furnishes large amounts of biologically complete protein and important amounts of vitamin B complex, which includes biotin, choline, folic acid, inositol, niacin, pantothenic acid, pyridoxine, riboflavin, thiamine, and vitamin B_{12}. On the basis of its rich contribution of nutritional essentials, meat well deserves its prominent place in the daily diet of the American people, the world's best-nourished people.

1. Recent estimates of the U. S. Department of Agriculture indicate that the per capita consumption of meat in the United States approaches seven ounces per day.
2. Watt, B. K., and Merrill, A. L.: Composition of Foods—Raw, Processed, Prepared, In Agriculture Handbook No. 8, United States Department of Agriculture, 1950.
3. Estimated on basis of protein content of meats. Sherman, H. C.: Food Products, ed. 4, New York, The Macmillan Company, 1948, p. 155.
4. Ohio animals; varies with iodine content of feed. Johnson, H. J.: Bridges' Dietetics for the Clinician, ed. 5, Philadelphia, Lea & Febiger, 1949, p. 800.
5. Mitteldorf, A. J., and Landon, D. O.: Analytical Chemistry; Spectrochemical Analysis of Beef for Mineral-Element Content, Armour Research Foundation of Illinois Institute of Technology. In Press.
6. Dauphinee, J. A.: Sodium, Potassium, and Chloride Malnutrition, Including Water Balance and Shock, in Jolliffe, N.; Tisdall, F. F., and Cannon, P. R.: Clinical Nutrition, New York, Paul B. Hoeber, Inc., 1950, p. 341.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

American Meat Institute

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This space is reserved for the usual monthly advertisement of Hoye's Sanitarium, Meridian, Mississippi pending change of name and preparation of approriate advrtising matter. The name of the institution was changed on January 14, 1952, to THE EARLE JOHNSON SANATORIUM.



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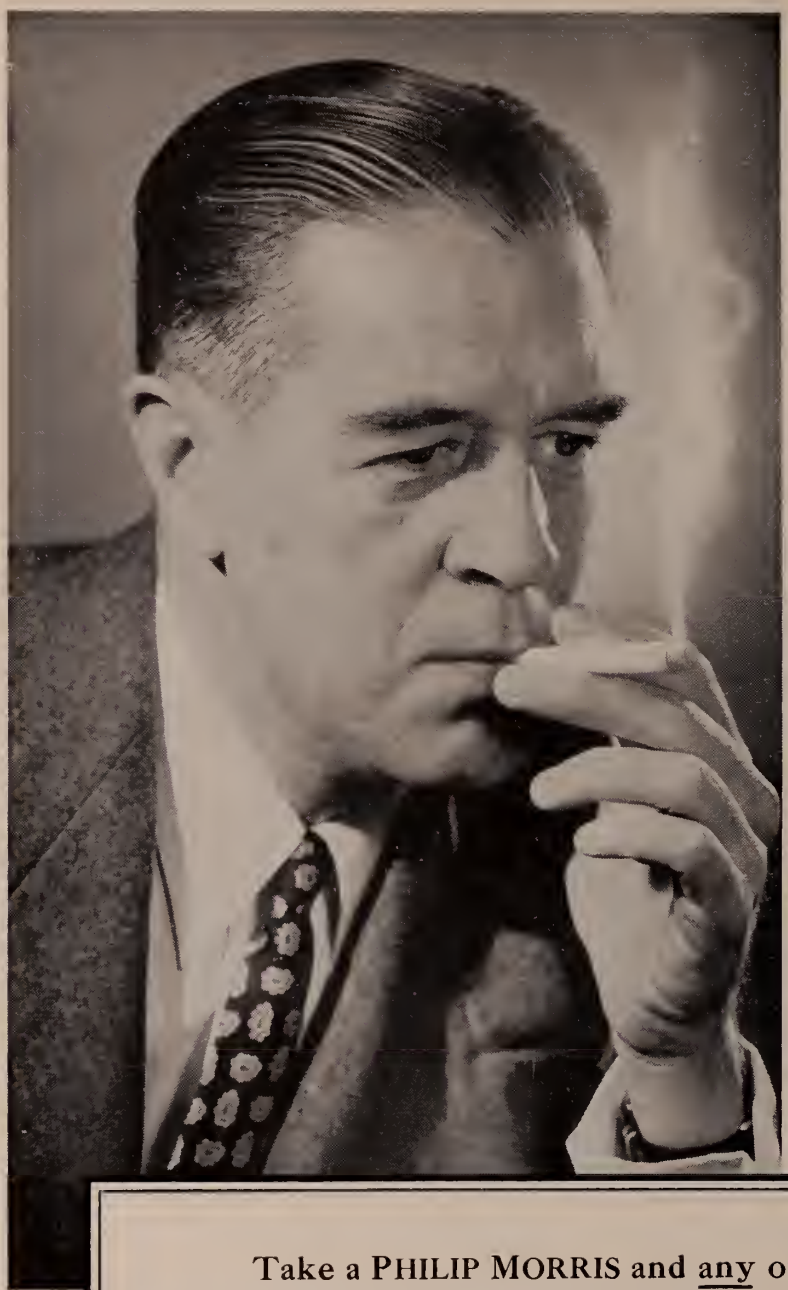
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	Little River 260 N. E. 79th Street, Rm. 3	Sarasota	237 Main Street, Room 15
	Coral Gables 3028 Biscayne Blvd.	Fort Pierce	Florida Bank Building, Room 34
	Miami Beach 3028 Biscayne Blvd.	Daytona Beach	116½ Orange Avenue
St. Petersburg	515 White Building	Tallahassee	429 Centennial Building
Lakeland	206 Marble Arcade	Panama City	142 Harrison Avenue
West Palm Beach	410 Datura Street	Pensacola	501 Theisen Building
Orlando	209 Slayton Building		



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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '52
Florida Medical Districts	William C. Roberts, Panama City	Council Chairman	
A-Northwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Panama City, 1952
B-Northeast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Daytona Beach, 1952
C-Southwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	St. Petersburg, 1952
D-Southeast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Ft. Pierce, 1952
Florida Specialty Societies			
Academy of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	Hollywood, Apr. 27, '52
Allergy Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	" "
Anesthesiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
Chapter, Am. Coll. Chest Phys	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
Derm. and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
Health Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	" "
Industrial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	Miami, May 8-10, '52
Neurology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	Hollywood, Apr. 27, '52
Ob. and Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
Ophthal & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	" "
Orthopedic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	" "
Society of Pathologists	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Lauderdale	" "
Pediatric Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	" "
Proctologic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	" "
Radiological Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
Urological Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
Florida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 7, '52
Blood Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
Blue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 27, '52
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks Jacksonville	" "
Dental Society, State	John I. Todd, D.D.S., Jacksonville	Tom Price, D.D.S., Miami	Jacksonville, Apr. 20-23, '52
Hospital Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Beach, Nov. '52
Medical Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	Jacksonville, June 29-July 1, '52
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 23-28, '52
Nurses Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
Pharmaceutical Association, State	Mr. Euless Watford, Chipley	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-21, '52
Public Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct., '52
Tuberculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Pt. St. Joe	Daytona Beach, May 15-17, '52
Woman's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	Hollywood, Apr. 27-29, '52
American Medical Association	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Chicago, June 9-13, '52
A.M.A. Clinical Session	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
Southern Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, 1952
Alabama Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19, '52
Georgia, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 11-14, '52
S. E. Hospital Conference	Edwin B. Peel, Atlanta	Mr. R. G. Ramsey, Jr., Memphis	Atlanta, Apr. 16-18, '52
Southeastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath. B. MacInnis, Columbia, S. C.	Augusta, Ga., Mar. 21-22, '52
Southeastern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	Boca Raton, Apr. 2-5, '52
Southeastern Surgical Congress	Joseph S. Stewart, Miami	B. T. Beasley, Atlanta	Atlanta, Mar. 10-13, '52
Gulf Coast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct., '52

President's Address

Seventy-Eighth Annual Convention

First House of Delegates Meeting

Hollywood, Tuesday Morning

April 29, 1952

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Total	MEMBERS Paid	COUNCILOR
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		21	3	
	Escambia *Santa Rosa*	Chas. J. Heinberg, M.D. Box 151 Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	73	38	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	William P. Blackmon, M.D. Apalachicola	Last Wednesday	8	7	A-1-52 Arthur J. Butt, M.D. Pensacola
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	16	9	
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	15	
	Washington-Holmes	George W. Carter, M.D. Chipley	Bayllye W. Dalton, M.D. Chipley		6	100%	
	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	15	10	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	56	7	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		8	2	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		4	1	
	Taylor *Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	1	227
B	Alachua *Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	49	45	
	Duval *Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	247	35	
	Marion *Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	28	12	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	9	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	11	6	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	12	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	20	4	
	Lake *Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	27	17	
	Orange *Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	151	12	B-4-53 Eugene L. Jewett, M.D. Orlando
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	15	2	
	Volusia *Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	78	42	651
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	168	112	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	20	10	
	Pasco-Hernando- Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	15	10	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	179	155	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	42	6	
	DeSoto-Hardee- Highlands- Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	25	18	
	Lee-Charlotte- Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	25	22	C-6-52 Leldon W. Martin, M.D. Sebring
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	91	68	565
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	1	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	116	87	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	St. Lucie- Okeechobee- Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	1	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	81	51	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	586	228	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	James B. Parramore, M.D. Box 326	Herman K. Moore, M.D. 600 Elizabeth St.	2nd Thursday 8:00 P.M.	11	9	

SCHEDULE OF COMING EVENTS WHERE WE WILL EXHIBIT . . .

FLORIDA STATE MEDICAL, APRIL 27-30

HOLLYWOOD BEACH HOTEL, HOLLYWOOD, FLORIDA

VISIT US AT **BOOTH 44** — SEE MANY NEW ITEMS

AMERICAN UROLOGICAL ASSOCIATION SOUTHEASTERN SECTION, APRIL 2-5

BOCA RATON CLUB, BOCA RATON, FLORIDA

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SOUTHEASTERN HOSPITAL CONFERENCE, APRIL 16-18

ATLANTA BILTMORE HOTEL, ATLANTA, GEORGIA

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Surgery, Common Bile Duct
Alpheus T. Kennedy

Pulmonary Embolism
David A. Newman

His Name Was Mudd
An Editorial

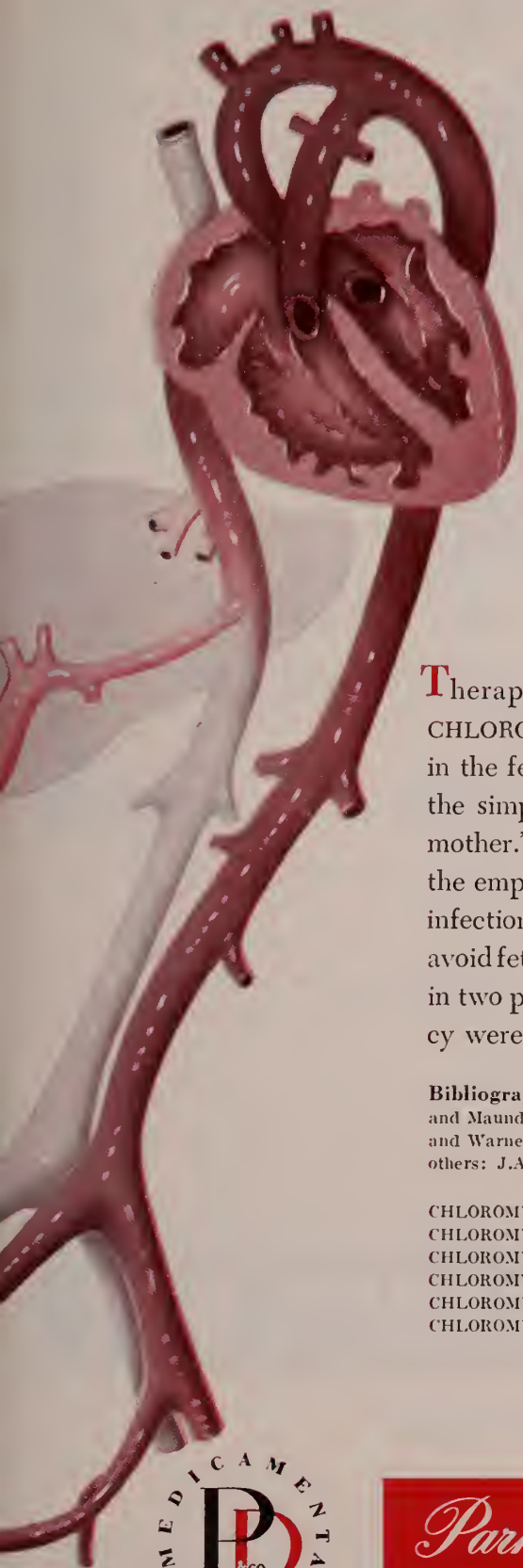
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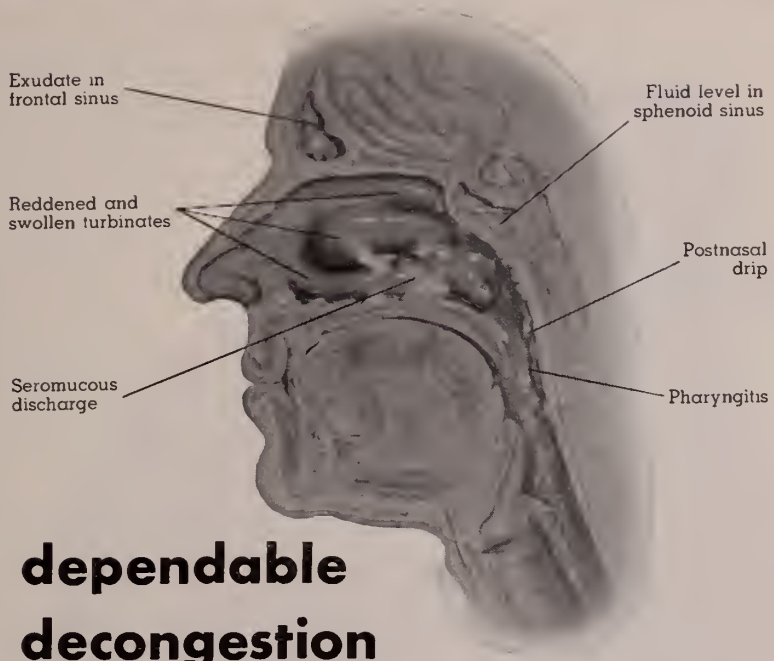
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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.



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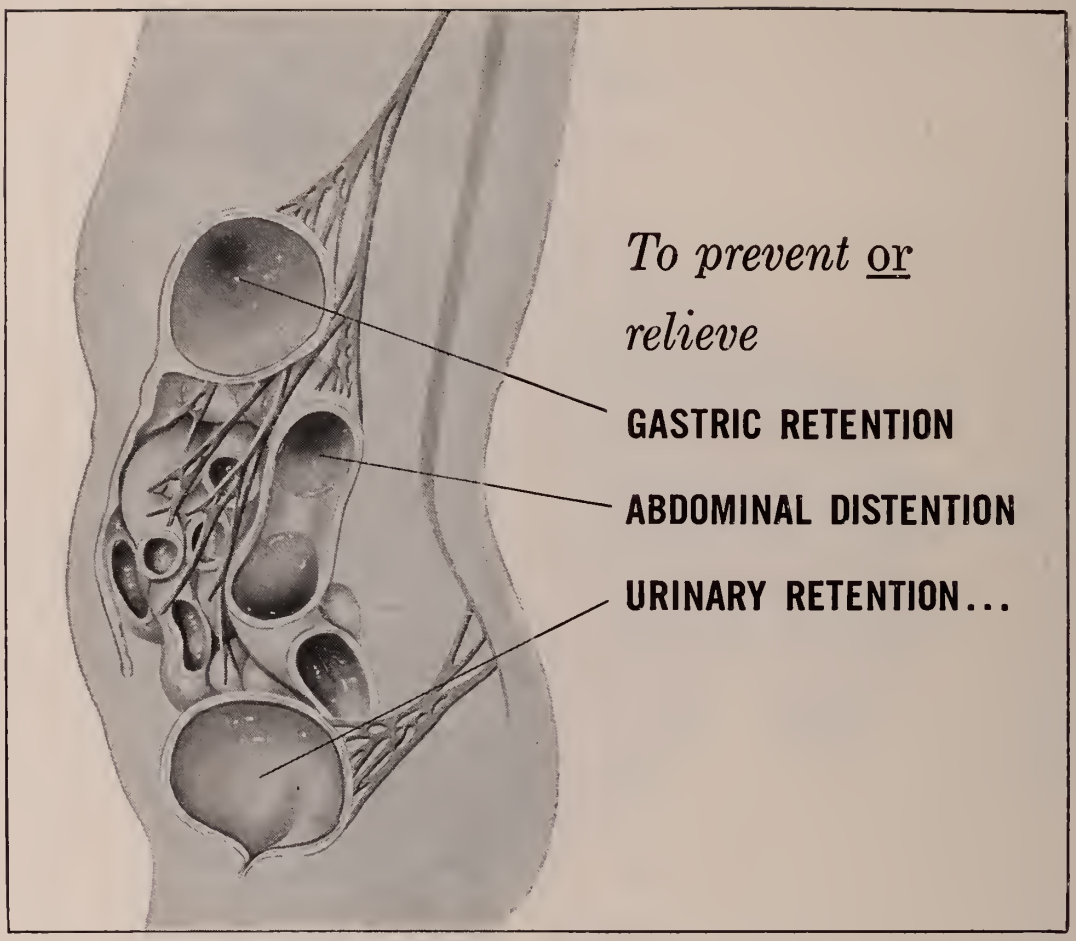
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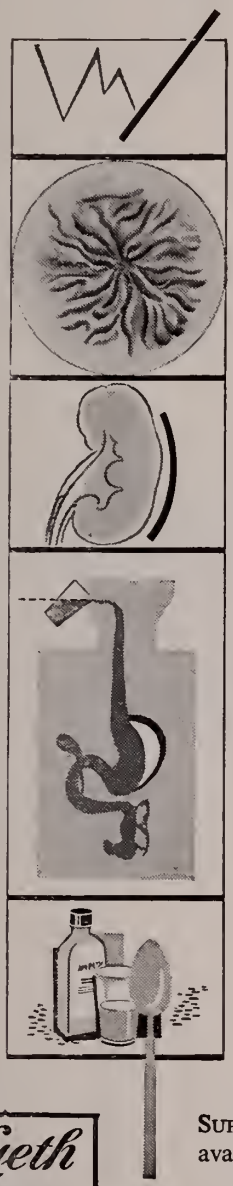
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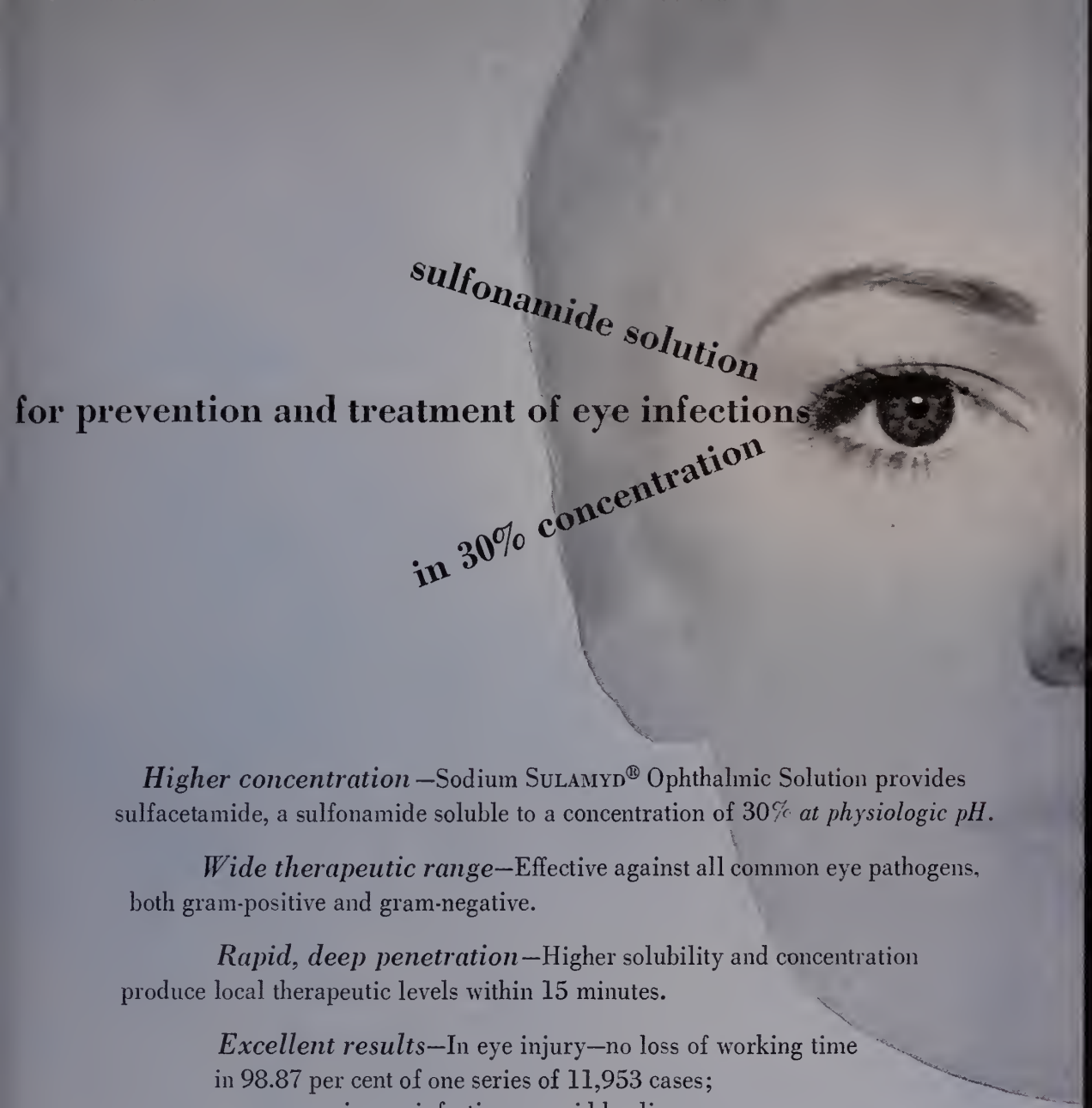
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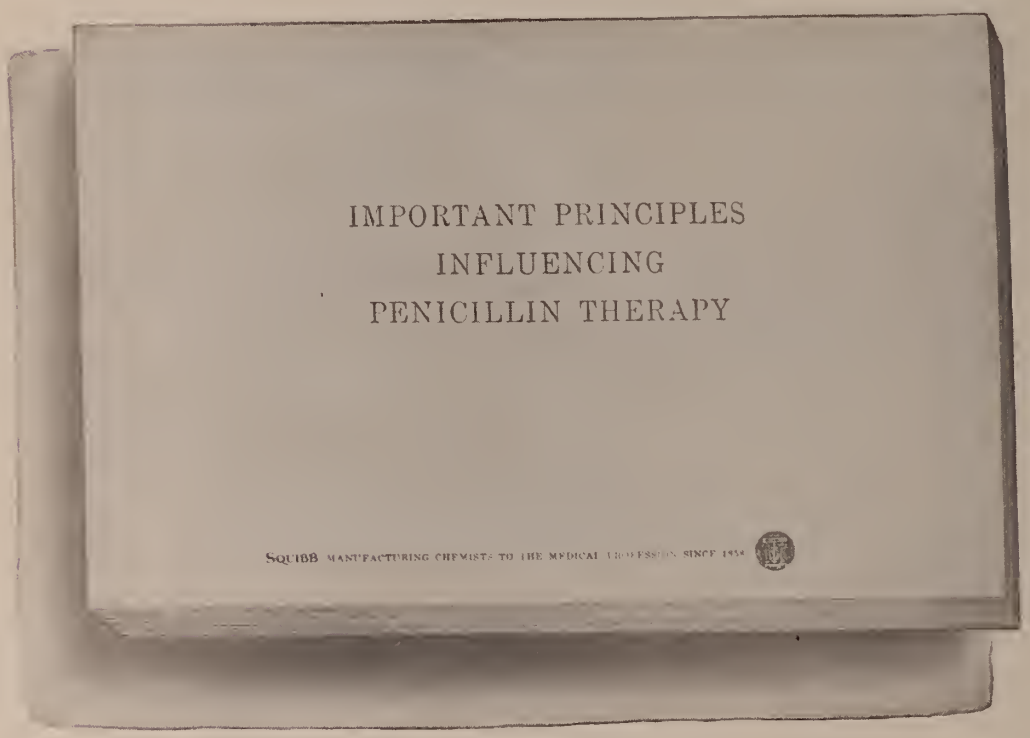
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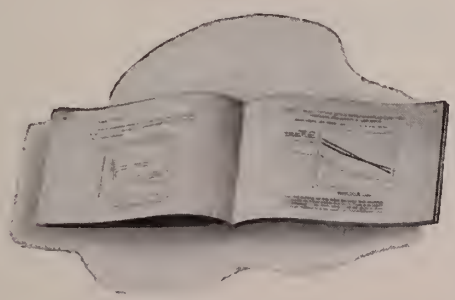
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Sprague, R. G.: Cortisone and ACTH, Am. J. Med. *10*:567, 1951.

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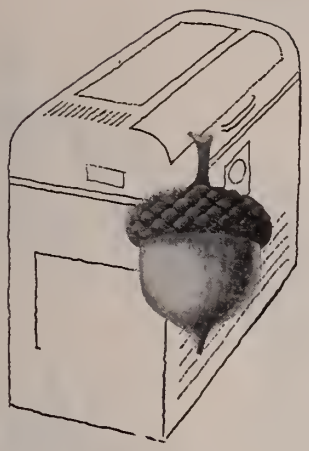
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1. Perloff, Wm. H., (1951) Treatment of the Menopause. II. Amer. J. Obst. & Gynec., 61:670, March. 2. Reich, W. J., et al. (1951), A Recent Advance in Estrogenic Therapy. I. American J. Obst. & Gynec., 62:427, August.

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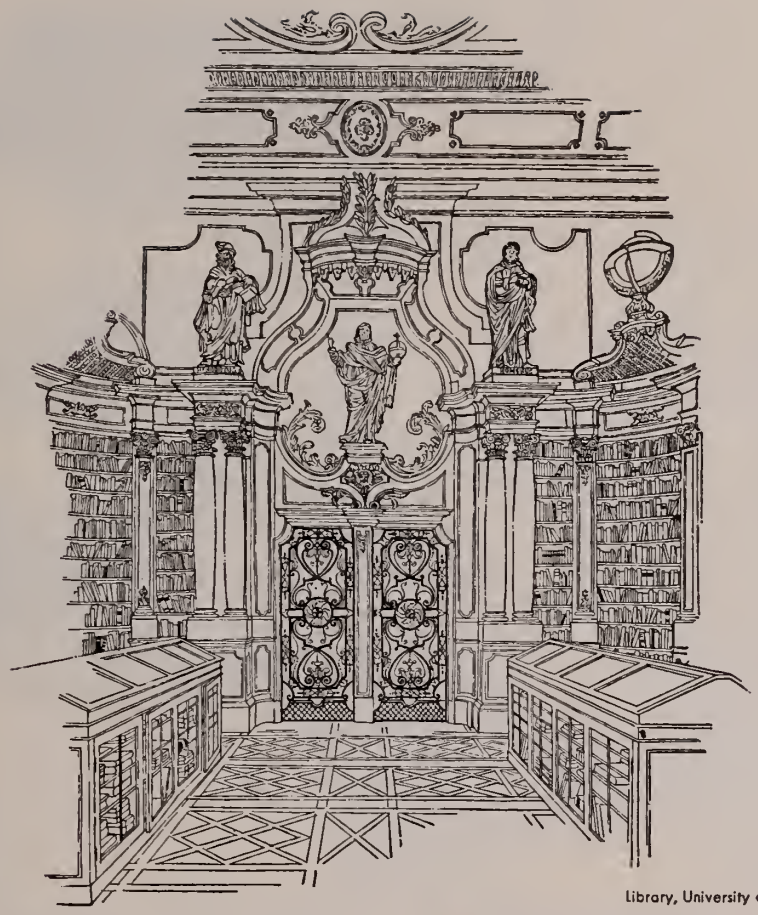
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**J. Pediat. 39:325, 1951*

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
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Volume XXXVIII | Jacksonville, Florida, April, 1952 | No. 10

Experiences in Surgery of the Common Bile Duct

ALPHEUS T. KENNEDY, M.D.
PENSACOLA

Surgery on the common bile duct is extremely interesting and presents a challenge to the surgeon to give his best performance in order to secure desired results.

An operation on the common bile duct above the duodenum was first described by Kummell[1] in 1890 and then by Thornton[2] in 1891. McBurney[3] performed a transduodenal operation first in 1892 for a stone at the ampulla of Vater. He did not open the common duct above the duodenum. By 1898 he reported 6 cases with 5 recoveries. Kocher[4] first performed a transduodenal operation in 1894, cutting through the duodenum and into the common duct and not the sphincter. The common duct and duodenum were sutured in side to side anastomosis.

Actually there are no signs or symptoms which enable the surgeon to determine, prior to operating, what is the exact cause of disease in the biliary system. Many laboratory procedures have been devised and are in general usage which are a help in determining whether or not jaundice is of an obstructive type. These tests are merely adjuncts and occasionally cloud the issue and mislead one who leans too heavily on them. It is also true that disease of a serious nature may exist in the common duct without giving rise to jaundice or colic.

What then are the reasons for exploring the common bile duct?

1. Jaundice or a history of intermittent attacks of jaundice. Here the history and laboratory procedures must be carefully evaluated, particularly when jaundice is present during the present illness.
2. Dilated or thickened common bile duct.
3. Palpation of a stone in the common bile duct, or inability to determine the cause of a suspicious mass. Lymph nodes are often found in the gastrohepatic ligament, and care must be exercised in determining whether a suspicious mass is a stone in the common duct or a lymph node alongside of the common duct.
4. Multiple small stones in the gallbladder.
5. Noncalculous gallbladder and history of biliary colic.

Exploration of the common bile duct is not advocated every time the gallbladder is removed, but it should be carefully exposed and the decision based on a consideration of the findings in conjunction with the history. This evaluation is essential to avoid performing an unnecessary exploration of the common duct and, what is more important, to avoid leaving behind a pathologic condition in the common duct that has not been adequately dealt with.

Analysis of Series

During the year July 1, 1949 to June 30, 1950, while I served as Senior Surgical Resident at the Duval Medical Center in Jacksonville, 60 patients were operated upon for disease of the extrahepatic biliary system. Cholecystectomy alone was performed on 40 patients; cholecystectomy and choledocholithotomy on 8 patients; and choledochotomy alone on 5 patients. Three patients had duodenocholedochotomy. Four patients had cholecystojejunostomy. An exploratory operation only was performed on 2 patients, who were found to have atresia of the extrahepatic biliary ducts.

The causes of obstruction as found at operation were:

Common duct stone	11
Fibrosis of ampulla of Vater	5
Carcinoma of head of pancreas	4
Congenital defects	2
Cholangitis	1
Stone lodged at ampulla of Vater	1

Read before the Florida Medical Association, Seventy-Seventh Annual Meeting, Hollywood, April 23, 1951.

Surgical Treatment

How then does one approach and deal with the various causes of obstruction? Stones are removed by scoops, stone forceps and irrigations of warm saline solution through a supraduodenal opening in the common duct. Probes and graduated dilators are then passed gently along the common duct and into the duodenum. As a final precaution, it is my practice to pass a catheter down the common duct towards the duodenum. This catheter is then irrigated with warm normal saline solution, and if none of the fluid is returned, it is assumed that the duct is patent to the duodenum.

Occasionally when it was thought that a probe had been passed into the duodenum, the injection of saline solution into the catheter gave immediate return, and further investigation revealed either more stones or a pathologic condition at the ampulla of Vater.

Stones, fibrosis, polyps, adenomas and carcinomas have been reported as causes of obstruction at the ampulla of Vater. Stones, polyps and adenomas are simply removed. The treatment of carcinoma of the ampulla of Vater requires radical surgery.

Fibrosis of the ampulla can be treated by introduction of graduated Bakes dilators, but this is occasionally followed by more scarring. This condition is best treated by a combined supraduodenal and transduodenal approach. A plastic operation is performed on the ampulla by cutting the sphincter and leaving a T tube in the common duct with one limb extending into the duodenum. The T tube serves as a splint to prevent a recurrence of the scarring and fibrosis and can be left in place for many months. Cattell[5] developed a T tube with one limb long for this purpose, but often an ordinary T tube is of sufficient length to be serviceable. The T tube is irrigated daily with distilled water and remains clamped off after the first seven to ten days postoperatively. A T tube is also left in place after removing stones, polyps or adenomas. Force should not be used in trying to pass probes or dilators. False openings may be made as a result. Damage to the pancreas or pancreatic ducts may occur.

The treatment of obstruction due to carcinoma of the head of the pancreas is first to relieve the obstruction. Numerous operations have been devised for radical removal of the pancreas and surrounding structures. In the 4 cases in this series distant metastases were already present, and thus the situation was hopeless. The five year salvage is practically nil even in the most favorable cases. In the cases reported treatment consisted of cholecystojejunostomy. This simple procedure allowed digestion and afforded the patients palliation for their remaining days. It is important to note that the status of the common duct should be determined before removing the gallbladder that might be of use in joining the biliary system to the gastrointestinal tract.

The patient with cholangitis was treated with exploration and T tube drainage of the common duct. He had an acute cholangitis, which is often a rapidly fatal disease. With the aid of chemotherapy and supportive measures, however, he survived.

The 2 patients with congenital defects had atresia of all of the external biliary apparatus including the gallbladder, cystic duct, common duct and hepatic ducts. These patients were infants, who received only exploratory laparotomy and eventually died.

Thus it is evident that the various types of obstruction which one may encounter are varied and demand individual attention to arrive at the proper solution in any given case. While it is true that opening the common duct adds to the length of any operation and mobilization of the duodenum with transduodenal exploration of the common duct is even more surgery, to leave behind disease in the common bile duct inadequately treated is a matter of serious portent. As stated earlier, I do not advocate opening the common bile duct in every patient operated upon for gallbladder disease. On the other hand, it is the responsibility of the operating surgeon to determine that the extrahepatic biliary ducts are patent and give evidence of no pathologic condition requiring surgical intervention.

In discussing the operative procedure, it is well to state at the beginning that every surgeon has his own technic and that this is to be desired. Certain surgical principles, however, should be followed. The type of incision employed is usually a subcostal incision and, if carried just beyond the midline on the left, it gives excellent exposure, particularly on short obese patients. The round ligament should be cut and carefully ligated. On tall thin patients a right paramedian or right rectus incision is utilized.

The common duct and its junction with the cystic duct should be carefully exposed by sharp and blunt dissection. The duct is palpated for

stones, and often if the operating surgeon will leave his position and go to the other side of the table (to the patient's left side), stones can be detected which are not otherwise felt. Before the common duct is opened, additional information can be obtained occasionally by aspiration of the bile with a 21 gauge needle and a 20 cc. syringe. The bile is then injected on a clean sponge. If the duct is normal in appearance, if the bile is clear, and if the patient's history is not indicative of jaundice, the common duct is not explored.

When the decision to open the common duct has been made, it is either grasped with Allis clamps or two sutures of fine material are placed in the duct and a longitudinal opening made between the sutures.

The duct is aspirated, and stones are removed by scoops or stone forceps, or often can be milked back up the common duct until they can be grasped with a stone forceps. A flexible probe is introduced and gently guided to enter the duodenum. As previously mentioned, force should not be used because of danger of making a false opening or injury to contiguous structures. Graduated dilators are then introduced, and if all goes well, a catheter of appropriate size is used to lavage the hepatic and common ducts and the catheter is passed into the duodenum. The surgeon must make every effort to be certain that the biliary system is open and draining well before considering the operation completed.

If obstruction is met with, then the right lateral edge of the duodenum is freely mobilized. The duodenum is opened longitudinally and exploration of the ampulla of Vater and the common duct completed. The duodenum is closed transversely with an inner layer of 00 or 000 chromic catgut and an outer layer of interrupted 000 silk. The common duct is closed about the T tube with interrupted stitches of 000 chromic atraumatic catgut.

The T tube is allowed to drain for several days and is then clamped off gradually. A cholangiogram is made before removal of every T tube. If the patient is being treated for disease at the ampulla of Vater, the T tube is left in place for several months and irrigated daily.

For the purpose of illustration, 2 cases are described.

Report of Cases

Case 1. — On Aug. 21, 1949, an 81 year old white man was admitted to the hospital with the chief complaint of abdominal pain. The patient had had a cholecystostomy six months previously at this hospital. At that time the gallbladder was drained, and several stones were removed. A cholangiogram made through the drainage tube showed blocking near the ampulla of Vater. The patient had been well thereafter except for an operative wound hernia until forty-eight hours prior to admission when there developed severe pain in the right upper quadrant of the abdomen. This was followed by nausea and vomiting. The pain was colicky in type and radiated around the costal margin to the back. In the four hours immediately before admission, the pain had been steady and had increased markedly in severity.

The physical examination revealed an 81 year old white man who was well nourished and well developed. The patient tossed from side to side and only after the administration of narcotics was it possible to examine him. The abdomen was rigid. There was a yellow tint to the skin.

At operation, the gallbladder was ruptured near the fundus, around the old fistulous drainage tract. There was stenosis of the ampulla of Vater, and the common duct and cystic duct were dilated. The common duct was opened, and with the use of Bakes dilators the ampulla was dilated until a size 18 Bakes dilator would pass with ease. A T tube was placed in the common duct with one limb going into the duodenum. The gallbladder was removed, and the hernia was repaired.

The postoperative course was somewhat stormy. The T tube was left in place four months. The patient is asymptomatic at the present time.

Case 2.. — On Feb. 12, 1950 a 60 year old white woman was admitted with the chief complaint of pain in the abdomen. For two days she had had pain in the right upper quadrant, nausea, vomiting, itching of the skin, clay-colored stools and dark urine. She had had a cholecystectomy at the Duval Medical Center twenty-nine months prior to admission. The common duct was explored at that time. Four months after the operation the patient began to have intermittent episodes of pain in the right upper quadrant, nausea, vomiting, light-colored stools and dark urine. These occurred every three to six months and for the last six months had been occurring every two months.

The physical examination revealed a slightly obese white woman whose skin had a yellow color and showed excoriation and irritation from scratching. The temperature was 100 F. The pulse rate was 100, and the blood pressure was 120 cystolic and 70 diastolic.

There was a well healed subcostal scar in the right upper quadrant. The remainder of the physical examination gave essentially negative results except that the left great toe was missing, having been removed previously for treatment of diabetic gangrene.

A review of the old hospital chart showed that the patient had had a cholecystectomy in October of 1947. The common duct was blocked by a stone at the ampulla of Vater. The stone was milked backwards and removed through the opening in the common duct. Many small stones were removed also. Bakes dilators were passed easily into the duodenum after all the stones had been removed. A cholangiogram showed that the dye went into the duodenum.

At operation, there was a stenosis of the ampulla of Vater, and dilators could not be passed into the duodenum. It became necessary to open the duodenum and incise the ampulla of Vater. A T tube was then placed in the common duct with one limb of the T tube passing into the duodenum.

The postoperative course was stormy. The T tube was allowed to remain in place for three months. The patient has had no further difficulty.

Conclusion

The various types of obstruction to the common bile duct which one may encounter are varied and demand individual attention in order to arrive at the proper solution in any given patient.

When a surgeon operates upon a patient for biliary disease, it is his responsibility to determine that the extrahepatic biliary ducts are patent and give evidence of no disease requiring surgical intervention.

A pathologic condition at the ampulla of Vater is best handled by a combined transduodenal and supraduodenal approach.

A series of 60 surgical cases of disease of the extrahepatic biliary system is reported. Two cases illustrating surgery of the common bile duct are described.

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Discussion

DR. EDWARD JELKS, Jacksonville: Dr. Kennedy, in his excellent paper which lays so much stress upon thoroughness and care in surgery of the biliary tract, introduces one point around which I should like to group my remarks, namely, that of seeing the biliary tree. If you do not see it, perhaps you will observe some of the unpleasant experiences that I have noted during thirty-six years of practicing surgery.

About twenty-four years ago I received a severe reprimand which has helped me ever since. We did a cholecystectomy upon a 48 year old woman. A few small stones were present. The operation was so simple it did not appear that any trouble could arise later. If some of you remember him, I am sure you realize the critical eye of the surgeon who watched me perform that operation. Dr. Knox Simpson was standing at the table as a helpful critic. After removal of the gallbladder, in a few days there developed jaundice, which cleared up immediately. Everything went along all right for about four months and then jaundice reappeared. Realizing that postoperative stricture probably was present, we sent the patient to the late Dr. Judd at the Mayo Clinic.

Not long afterward, it was my pleasure to talk with Dr. Judd about this patient, and he said, "That was a funny thing I found at operation; the common duct was intact, but it was constricted from the junction with the cystic duct to the duodenum. How did it look when you saw it at operation?" I replied, "It felt all right, Dr. Judd." He repeated, "How did it look?" That admonition by a distinguishd surgeon has not for a minute escaped my memory at any kind of operation for disease of the gallbladder.

This case is an example of the treacherous so-called "simple gallbladder," one that is easily accessible, which the surgeon thinks is so readily removable that no damage can be done to the patient. So, he merely palpates the biliary tree and does not expose it to view. Since being careful to visualize the biliary tree, we have made some interesting observations about it. There may be various locations and degrees of narrowing of the lumen. At the present time we are observing 2 or 3 patients to see what is going to happen to their biliary ducts. We know they have constrictions which at operation were not sufficiently developed to cause jaundice and bile was passing into the gastrointestinal tract.

Not long ago we operated upon a doctor who had jaundice. The gallbladder was perfectly normal except for a few small stones, but the common duct looked quite like some one sees in infants with multiple congenital constrictions. Bile came through partially, but the whole tree was involved. If we had not been careful to dissect out and visualize the biliary tree, in spite of some difficulty in doing so, we would have completed the operation without having correct information about the bile ducts, and when jaundice developed later, necessitating another operation, we would have criticized ourselves, thinking that at the previous operation we had injured the biliary tree.

It is just as important to be sure there is nothing wrong with the biliary tract as to find a lesion in it. With the ducts exposed, the liability of trauma to it is minimal. So, look and do not palpate only.

DR. WILLARD F. ANDE, West Palm Beach: Dr. Kennedy has given us a comprehensive discussion of the indications, the operative technic and the findings to be expected in surgery of the common duct. I was happy to hear, along with Dr. Jelks, his re-emphasis on the exposure of the common duct at the time of a cholecystectomy. Happily, I have witnessed no bad effects when this was not done, but as Dr. Jelks has emphasized, symptoms may recur, to the embarrassment of the surgeon and to the great discomfort of the patient.

Since many cases of this type occur in aged patients, the problem of a "prophylactic" cholecystectomy and perhaps choledochotomy in these patients arises. Many of you here have had patients, followed along by the family physician, who perhaps have disease of the extrahepatic biliary system and also actual known stones, cholelithiasis, but in addition they have, perhaps, some cardiac disability or a renal impairment with slight elevation of nonprotein nitrogen and perhaps a moderate to severe degree of sclerosis. The family physician carries them on from year to year and perhaps without any serious complications, but we have no way of knowing how many of these patients die as a result of their cardiac or renal disease or some other complication, a cerebral accident or what not. When they come to you with stones in the common duct, with acutely inflamed gangrenous gallbladders, or perforated gallbladders, they are dehydrated from vomiting and are suffering from some degree of malnutrition and anemia. They are in pretty foul shape, perhaps toxic from a generalized peritonitis. In these days of modern anesthesia we have antibiotics, improved surgical technic, intravenous fluids, and the like, to thank for the lowered mortality in these patients.

Had the family physician, however, submitted the patient for consultation or survey at a time when the patient was relatively well, when the operation could have been planned at the time when the patient was in the best condition, I believe that many cases of perforated gallbladder or stones in the common duct in aged patients could have been avoided. Today, with more advanced anesthesia, with developments in technic, with antibiotics, I think that many of these patients should have an operation before they get into a serious condition and provide a mortality rather than a successful operation. Thank you for the opportunity to discuss this paper.

DR. KENNEDY, concluding: I desire to thank the discussers and to express appreciation of their emphasis of the various points. Occasionally in the group of patients Dr. Ande spoke of, the patient has been told that he is too old, that he is not in condition to stand an operation, and then you are faced with an emergency in a patient whose mental attitude is, "I'm not going to pull through." You who are surgeons know especially well how much the mental state of the patient counts, how much the confidence of the patient in the doctor means, and how much the feeling of the patient that he is going to get well helps. This is true in any patient regardless of age.

Electrocardiographic Changes in Pulmonary Embolism

David A. Newman, M.D.
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Pulmonary embolism may or may not give rise to specific changes in the electrocardiogram.[1,2] Actually, because the lesion is primarily pulmonary and not cardiac, there may be no significant typical electrocardiographic changes at all; or, only one or two of the changes may be present in a given case.[3] Unless the genesis of these changes is understood, they can be most confusing and are then too often passed off as the vague and ill-defined "myocardial damage."

In only about 10 to 20 per cent of cases of pulmonary embolism is there a characteristic electrocardiographic pattern. Electrocardiographic examination is therefore not a good method of making the diagnosis. This must still be clinical, and remains primarily dependent on the old "high index of suspicion." Clinically, the most important clue in the diagnosis is a sudden onset of tachycardia and shock, with or without pain in the chest, usually in a patient at rest in bed, and particularly so either in the postoperative period, or during treatment for congestive failure.[4] Another important suggestive clinical clue is the onset of sinus rhythm in a patient previously experiencing fibrillation, in association with a sudden onset of suspicious thoracic symptoms. The classic manifestations of acute pain in the chest, bloody sputum, pleural friction rub, consolidation and effusion, and the too late Moses' and Homans' signs may never appear.[4]

A not uncommon picture is one characterized by slight pain in the chest, mild cough and slight fever, without any definite physical signs other than, perhaps, a few basal or axillary crepitant rales. This has often passed as a pulmonary "virus infection." When it occurs in a patient in congestive failure, and particularly if it clears up rapidly, pulmonary embolism must be considered in the diagnosis.[9]

Read before the Florida Heart Association, Sixth Annual Meeting, Hollywood, April 22, 1951.

Because the electrocardiographic changes caused by pulmonary embolism are not always specific, and may not all be present in a given case, the configuration of the tracings will vary from patient to patient.[3] When present, however, and interpreted correctly in the light of their electrical genesis, these changes can serve to support the clinical diagnosis. This role is particularly important in the differential diagnosis between pulmonary embolism and myocardial infarction, especially that of the posterior wall. Recently, since the use of precordial V leads has become more general, the picture of anteroseptal infarction may also occasionally enter the differential diagnosis.

Many varied interpretations of the mechanism of pulmonary embolism have appeared in the literature.[2,5,6] The electrocardiographic criteria of pulmonary embolism were originally described by McGinn and White[2,5,6,7] in 1935 at a time when the precordial Wilson leads were not yet in common use. These authors emphasized the presence of an S in standard lead 1, a Q in lead 3, and a negative T in lead 3, associated with depression of the ST segment in leads 1 and 2 and elevation of the ST segment in lead 3.[8]

Since then, with the more general use of the V leads, many additional and varied patterns have been described.[2,6,9] Some authors have emphasized the changes characteristic of acute cor pulmonale;[1] others have emphasized the changes caused by clockwise rotation of the electrical axis of the heart with shift of the transitional zone to the left.[6] No doubt both are significant.

Following the case reports, which illustrate some of the more typical changes in pulmonary embolism, I will summarize the present views regarding the genesis of these changes in the electrocardiogram, as well as the criteria presently accepted as typical.

This report is the result of a study of 45 cases of pulmonary embolism in which treatment was given during the past six years at the St. Mary's

CASE 1

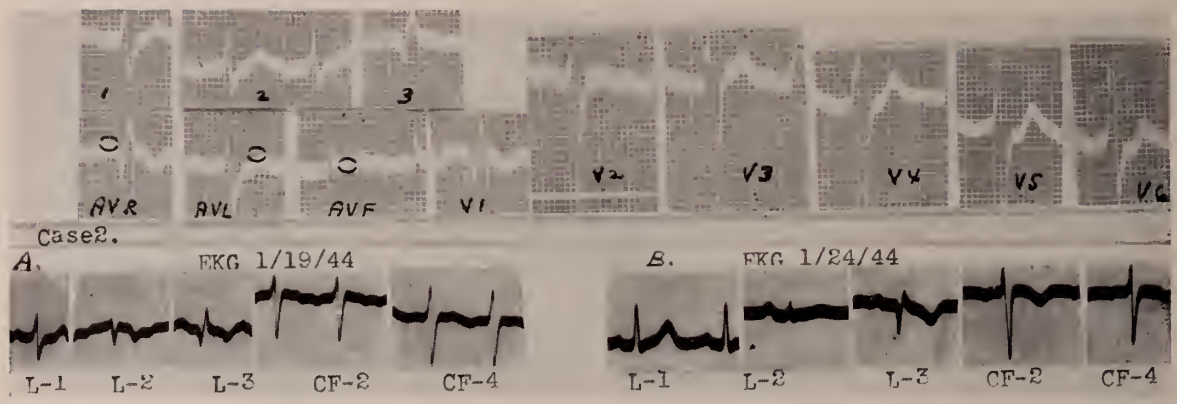


Fig. 1. — Case 1. Electrocardiogram taken twenty-three hours after the onset of pulmonary embolism. Deep S-1 and S-2, Q-3, elevated ST-3 and ST-AVF, late R in AVR and V-1, deep S in V-2 to V-6 and in VAL, small q and low diphasic T in AVF.

Case 2. (A) Electrocardiogram of Jan. 19, 1944, taken twenty-four hours after a third attack of pulmonary embolism. Broad S-1 and S-2, Q-3, negative T-3, depressed ST-1, elevated ST-3, deep S in CF-4, negative T in CF-2, diphasic T in CF-4.

(B) Electrocardiogram of January 24, on the same patient five days later. Pronounced diminution of S-1 and S-2, deeper negative T in CF-2 and CF-4.

and the Good Samaritan hospitals in West Palm Beach.

The purpose of the study was: (1) to correlate the electrocardiographic findings and diagnoses with the established diagnosis of pulmonary embolism, (2) to analyze the electrocardiographic changes present, in the light of the currently accepted criteria, and (3) to analyze the changes as to the mechanism that causes them.

Out of the 45 cases studied only those that presented unequivocal evidence in support of the diagnosis were selected for analysis. There were 21 such cases selected as the basis for this report. In all, one or more electrocardiograms were taken within twenty-four hours after the attack of pulmonary embolism. In 10 cases there were previous tracings for comparison.

The diagnosis in all these 21 cases was unequivocally supported by: (1) competent etiologic factors, (2) characteristic onset, symptoms, and signs, (3) characteristic course and progression, (4) adequate supportive laboratory and roentgen evidence, (5) electrocardiographic changes typical of pulmonary embolism in 8 cases and finally, (6) confirmation by autopsy in 5 cases.

Report of Cases

The 21 cases of substantiated pulmonary embolism were divided, on the basis of the electrocardiographic findings, into three groups:

I. Typical Group, Eight Cases

The electrocardiographic changes in this group were characteristic enough in pattern to make the diagnosis of pulmonary embolism possible. This is a larger percentage than the usually reported 10 to 20 per cent. Only 3 of these 8 cases (1, 4 and 5), however, were correctly interpreted at the time.

In summary, this group of 8 typical cases showed:

1. Evidences of clockwise rotation of the electrical axis of the heart, with shift of the transitional zone to the left, as seen in the precordial V leads. Depending on the position of the heart, this was transmitted to the limb and to the standard leads.
2. Evidences of right ventricular anoxia or ischemia causing T inversion and ST segment depression in the right precordial V leads.
3. Rapid reversion of these changes to normal.

Case 1.—J. A., a 67 year old man hospitalized on Oct. 28, 1949, had a positive blood Kahn reaction, hypertension, aortic insufficiency and cardiac enlargement. He was under treatment for congestive failure. There was a history of pain in the calf of the right leg on the night of admission. The onset on October 28 was typical, with acute pain in the chest, dyspnea, cyanosis, shock, syncope, tachycardia of 130, rales at the base of the right lung, and bloody sputum the next day; roentgen examination two days later showed "increased density of the lower half of the right lung field with probable pleural effusion." The patient improved at first, but died suddenly thirteen days after the onset in "acute respiratory failure."

The electrocardiogram of October 29 (fig. 1, case 1), taken twenty-three hours after the acute attack showed:

1. Deep broad S in leads 1 and 2.
2. Deep Q and negative T in lead 3.
3. ST segment elevation in lead 3 and in AVF.
4. QRS duration equal to 0.11—0.12 sec. (incomplete right bundle branch block).
5. Late R in V-1 and AVR.
6. Deep S in V-2 through V-6, and in AVL.
7. Small q and low diphasic T in AVF.

This case illustrates most of the features presently accepted as typical of pulmonary embolism.

It did not show the right ventricular "strain" pattern of T inversion in the right precordial leads, V-2 and V-3. It, however, did show the S-1, Q-3, negative T-3 pattern of McGinn and White and the pronounced clockwise rotation of the heart with shift of the transitional zone to the left.

The electrocardiographic diagnosis in this case was correctly reported as "probable pulmonary embolus."

Case 2.—L. D., a 72 year old woman admitted to the hospital on Jan. 19, 1944, had three episodes of pulmonary embolism in three weeks. Phlebitis of the right leg developed three weeks after an appendectomy for a gangrenous appendix. This was followed by three separate minor attacks of weakness with cold sweat and tachycardia. The third attack was also associated with pain in the chest, bloody sputum, fever, and a transient friction rub. Roentgen findings were confirmatory. The patient was discharged on February 2, and recovery was uneventful.

The electrocardiogram of January 19 (fig. 1, case 2A), twenty-four hours after the third attack, showed:

1. Tachycardia of 140.
2. Deep broad S in leads 1 and 2.
3. Deep Q-3 and negative T-3 (with late R-3).
4. ST depression in leads 1 and 2 (with so-called staircase ascent). ST elevation in lead 3 (with some coving).
5. Deep S in CF-4 suggesting clockwise rotation.
6. Negative T in CF-2 and low to diphasic T in CF-4, suggesting the right ventricular strain pattern.

The last two changes (5 and 6) are not as evident in the CF leads as they might have been in the V leads.

The electrocardiogram of January 24 (fig. 1, case 2B), five days later, showed:

1. Markedly diminished prominence of S-1 and S-2.
2. Deepening of the negative T in CF-2 and CF-4.
3. Q-3 and negative T-3 unchanged.

This case shows the typical McGinn-White pattern of S-1, Q-3, negative T-3 with ST depression in leads 1 and 2, and ST elevation in lead 3.

It also illustrates an important point in the differential diagnosis between pulmonary embolism and myocardial infarction of the posterior wall, which was missed here. The inversion of the T waves over the precordium, particularly over the right side of the heart (CF-2 and CF-4 in this case) does not occur in infarction of the posterior wall.[1] Rather, the T waves in the right precordial leads are reciprocally elevated and increased in amplitude.[8] They may remain unchanged, but are almost never inverted.[2] In pulmonary embolism they tend to become inverted, though this inversion may disappear in a short time.[10]

The electrocardiographic diagnosis in this case was "posterior wall infarction and (possibly) pulmonary embolism."

Case 3.—H. L. E., a 69 year old woman, had hypertensive arteriosclerotic heart disease and was in moderately severe congestive failure on maintenance doses of digoxin. She was admitted on Oct. 14, 1950 for pyelonephritis and renal calculus. Five days after admission she had a clinically typical attack of pulmonary embolism from which she recovered in seven days. Onset, course and all confirmatory findings were characteristic. She died three weeks later after nephrectomy on the left side.

The electrocardiogram of October 19 (fig. 2, case 3A), six hours after the attack, showed:

1. Prominent S in leads 1 and 2.
2. Deep Q and negative T in lead 3, and negative T in AVF.

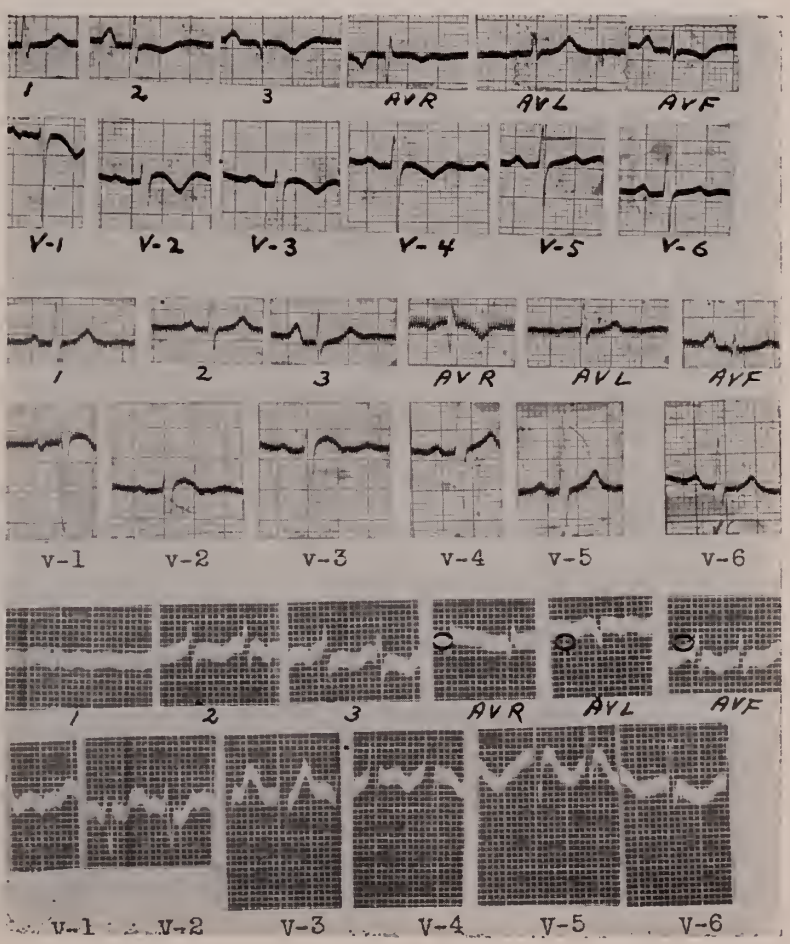


Fig. 2. — Case 3. (A)-10/19/50-Electrocardiogram taken on Oct. 19, 1950, about six hours after the onset of pulmonary embolism. S-1, S-2, Q-3, negative T-3, negative T in AVF and in V-1 through V-4, deep S through V-6, late r in AVR.

(B) - 10/25/50 - Electrocardiogram taken October 25 on the same patient. T-2 and T-3 up T-AVF up, T up in V-4, 5, 6, T less negative in V-2, 3, S smaller in V-6.

Case 4. — 3/6/50-Electrocardiogram taken nineteen hours after the onset of pulmonary embolism; auricular fibrillation. S-1, S-2, S-3, depressed ST-2 and ST-3, negative T in L-1, 2, 3, and AVF, negative T in V-4, 5, 6, late R and elevated ST in AVR.

3. Sharp T inversion in V-1 to V-4.
4. Deep S in V-1 through V-6 and in AVF.
5. Late R in AVR.

The electrocardiogram of October 25 (fig. 2, case 3B), six days later, showed almost complete reversion of some of the changes to normal. This was particularly true of the T waves in leads 2, 3 and AVF. The precordial T waves were now upright in V-4, 5, 6 and less negative in V-2, 3.

This case illustrates mainly (1) the typical right ventricular "strain" pattern, (2) the clockwise rotation of the electrical axis, as indicated by the shift of the transitional zone to the left, (3) the rapid reversion of the electrocardiographic changes to normal in contrast to those of myocardial infarction, and (4) the McGinn-White pattern in the standard leads.

The electrocardiographic interpretation in this case was "coronary heart disease, questionable apical infarct."

Case 4.—L. S., a 61 year old woman with pronounced hypertension of long standing, was under treatment for chronic congestive failure. Fibrillation had been present. At the onset of a clinically typical attack of pulmonary embolism there had been a transient change to regular sinus rhythm. She was admitted on March 6, 1950 and died three days later from mesenteric thrombosis. Autopsy showed two small recent pulmonary infarcts of the left lung, and a small recent apical myocardial infarct at the apex; also old rheumatic mitral and tricuspid stenosis.

The electrocardiogram of March 6 (fig. 2, case 4), nineteen hours after the attack, showed:

1. Auricular fibrillation.
2. Small s in lead 1, large S in leads 2 and 3, (but no Q-3).
3. ST slightly depressed in leads 2 and 3.
4. T negative in leads 1, 2, 3, and AVF.
5. T negative in V-1 and in V-4, 5, 6 (but not in V-2, 3).
6. Late R and elevated ST in AVR.

This case illustrates mainly the changes due to the clockwise rotation of the electrical axis, with shift of the transitional zone to the left, in a heart that was vertical despite long-standing pronounced hypertension.

Some of the changes due to the pulmonary infarction were partly obscured in this case by the coexistent apical myocardial infarct.

The electrocardiographic diagnosis was reported as "myocardial infarction, possible pulmonary embolus."

Case 5.—E. D., a 60 year old woman with recurrent thrombophlebitis, had the last attack two weeks before the pulmonary embolism, for which she was hospitalized on March 24, 1945. She had two separate attacks of pulmonary embolism clinically typical in onset and course, with recovery.

The electrocardiogram of March 26 (fig. 3, case 5A), six days after the first attack, showed:

1. Right bundle branch block with QRS of 0.12 sec.
2. Double-peaked widened R-R′ in CF-2 and CF-4.
3. Deep, broad large S in lead 1, small s in lead 2, (no Q-3), deep S in lead 3.
4. Late slurred widened R′ in lead 3.
5. T negative in leads 2 and 3 and sharply negative in leads CF-2 and CF-4.

The electrocardiograms of April 2 and 23 (fig. 3, case 5B and C), one and three weeks later, respectively, showed:

1. Complete disappearance of the right bundle branch block.
2. Development of deep S through CF-4 (due to clockwise rotation?)
3. The negative T waves in leads CF-2 and CF-4 persisted in this case.

This case illustrates the transient nature of the right bundle branch block often associated with pulmonary embolism.

The electrocardiographic diagnosis in this case was "probable pulmonary embolus."

Case 6.—B. C., a 71 year old man hospitalized on Nov. 9, 1950, was an arthritic with hypertensive cardiovascular disease and paroxysmal auricular fibrillation. The clinical onset of pulmonary embolism was atypical and silent. It was at first thought to be a "virus pneumonitis." The onset, however, was associated with a transient change to regular sinus rhythm. The subsequent course and studies, including the occurrence of embolic phenomena elsewhere, established the diagnosis.

The electrocardiogram of November 10 (fig. 3, case 6A), twenty-four hours after the acute episode, showed:

1. Auricular fibrillation.
2. Small s in lead 1.
3. Q and negative T in lead 3. (T negative in leads 1 and 2 as well.)
4. ST segment slightly depressed in leads 1 and 2 and slightly elevated in lead 3.
5. Deep S through V-5.
6. T inverted in V-4 through V-6 and AVL (ventricular "strain" pattern).

The electrocardiogram of November 13 (fig. 3, case 6B), three days later, showed:

1. Reversion to sinus bradycardia.
2. Disappearance of all the abnormalities mentioned.

This case illustrates (1) the association of pulmonary embolism with transient auricular fibrillation occurring often during the transition from auricular fibrillation to sinus rhythm, and (2) the rapid reversion of the electrocardiographic changes to normal.

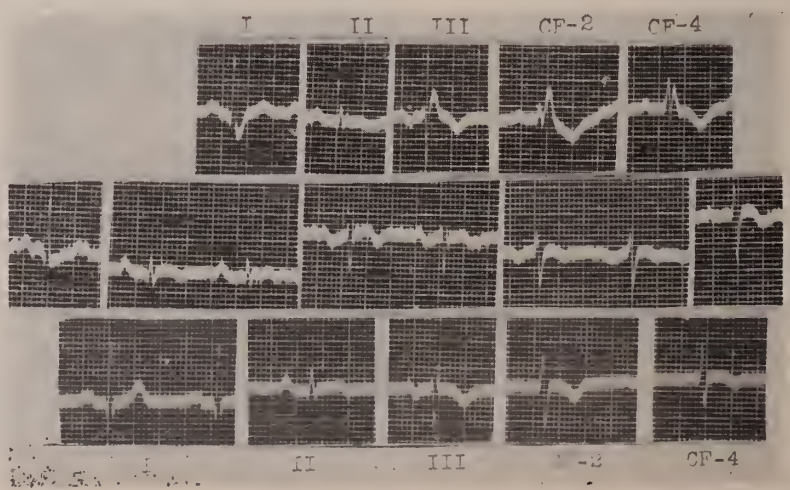


Fig 3.— Case 5. (A)-3/26/45-Right BBB with QRS of 0.12 sec., double peaking of R-R′ in CF-2 and CF-4, S-1, s-2, S-3, wide R′ in L-III, negative T in L-II, III, CF-2 and CF-4.

(B)-4/2/45-One week later, no bundle branch block, deep S through CF-4.

(C)-4/23/45-No change.

The electrocardiographic interpretation in this case was "myocardial damage, left ventricular strain."

Case 7.—K. P., a 69 year old woman, had a saphenous ligation on Nov. 14, 1950, followed by a non-healing varicose ulcer and cellulitis. Eight days later she had a clinically typical onset of pulmonary embolism accompanied by dypsnea, tachycardia (with extrasystolic arrhythmia), shock, pains in the chest, bloody sputum the next day, and elevation of temperature to 101 F. Signs on physical examination and roentgen findings were confirmatory. The course was typical with rapid improvement and recovery, and recurrence of pulmonary embolism some time later, after discharge from the hospital on Jan. 6, 1951.

The electrocardiogram of November 22 (fig. 4, case 7A), four hours after the acute episode, showed:

1. Regular sinus rhythm, 92 per minute.
2. Prominent S in lead 1 (no S-2).
3. Deep and wide Q and negative T in lead 3 and in AVF.
4. ST segment slightly depressed in lead 2 and slightly raised in lead 3. Thus far the findings could be consistent with infarction of the posterior wall. In the V leads, however, there is:
5. Sharp late (low) inversion of T in the right precordial leads V-1 through V-4 (the right ventricular "strain" pattern). T is low upright in V-5 and V-6.
6. S is prominent through V-4, 5, 6 and AVL. There is a late small r in AVR. Both are indicative of clockwise rotation.

The electrocardiogram of November 24 (fig. 4, case 7B), two days after the attack, showed little change except, perhaps:

1. T in V-4 now upright.
2. S more prominent in V-4, 5, 6.

The electrocardiogram of December 15 (fig. 4, case 7C), twenty-three days after the attack, showed complete reversion of all changes to normal:

1. T waves in the right precordial leads V-2, 3, 4 are now upright.
2. S in leads 1, AVL, and V-5, 6 is now much less prominent.
3. Q and negative T in AVF are less pronounced. Those in lead 3 are the same as in an old tracing of eighteen months before.

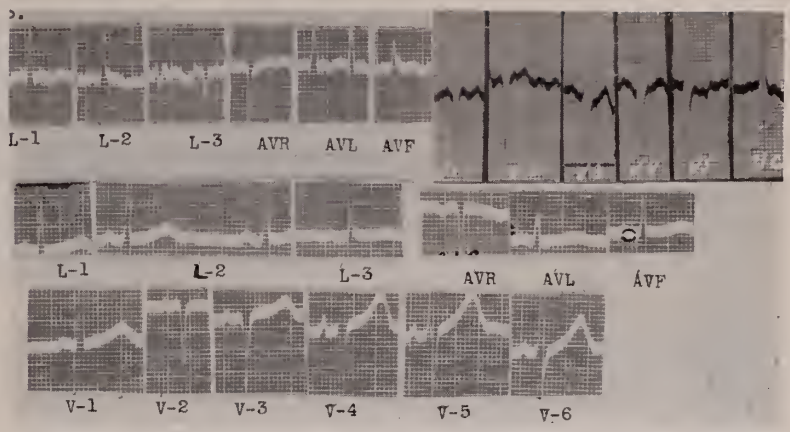


Fig. 3.—Case 6. (A)-11/10/50-Auricular fibrillations, s-1, Q-3, negative T-3, ST-1 and ST-2 down, ST-3 up, S through V-5, negative T in AVL and V-4 to V-6.

(B)-11/13/50-Sinus bradycardia, clearing of all abnormalities.

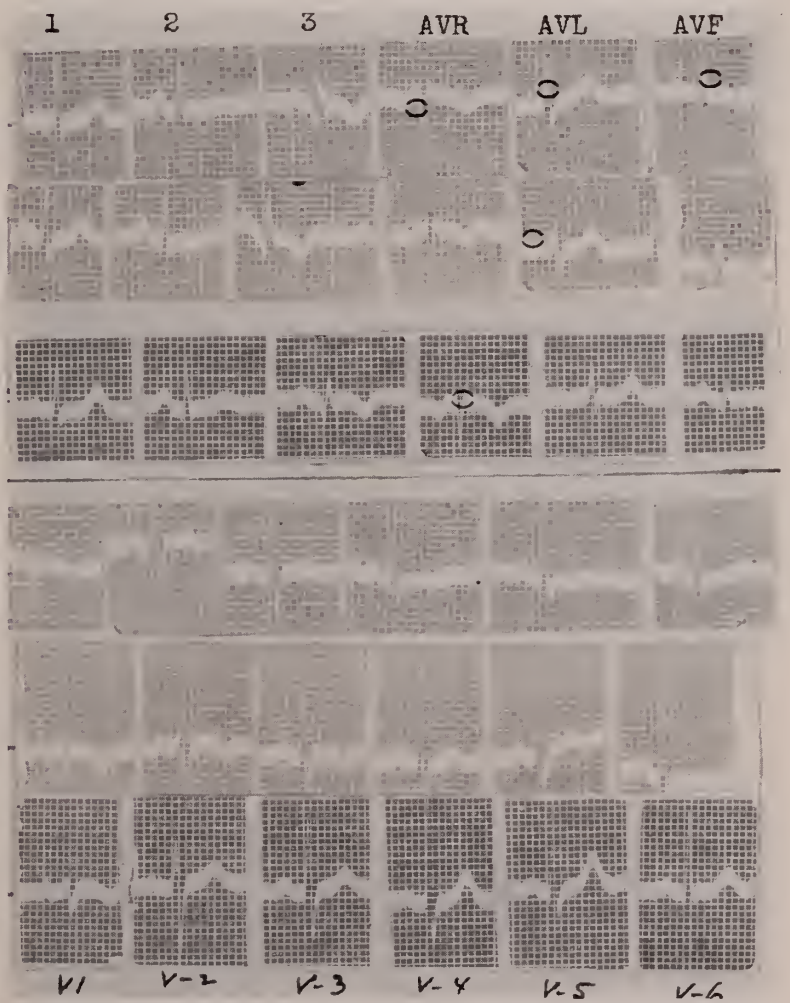


Fig. 4.—Case 7. (A) -11/22/50- S-1, Q-3, negative T-3, negative T-AVF, ST-2 down, ST-3 up, negative T in V-1 to V-4, S through V-6, S in AVL.

(B)-11/24/50-T up in V-4, S more prominent through V-6.

(C)-12/15/50-T up in V-2, 3, 4, s less prominent in L-1, AVL and V-5, 6, q in L-3 and AVF less pronounced.

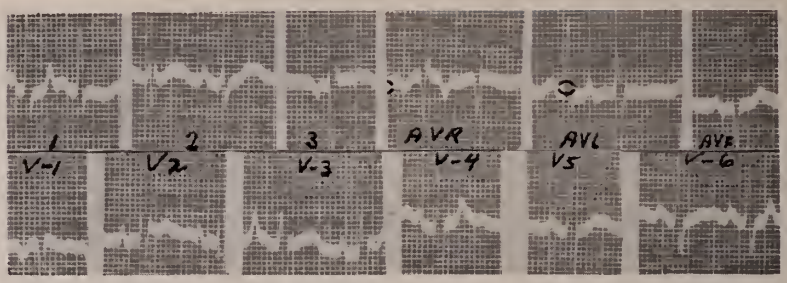


Fig. 5.—Case 8 -9/18/50- S-1, S-2 Q-3, diphasic T-3, Q-AVF, ST-1 and ST-2 down, ST-3 up, S through V-5, 6, late R in AVR.

This case again illustrates (1) the right ventricular "strain" pattern of inverted T waves in the right precordial leads, (2) their rapid reversion to normal in two days, (3) the McGinn-White pattern of S-1, Q-3, and negative T-3 in the standard leads, and (4) the pronounced clockwise rotation in the V leads.

At the time of its occurrence there was some question in the differential diagnosis between coronary thrombosis and pulmonary embolism. The electrocardiogram could have been materially helpful in making the differentiation.

The electrocardiographic interpretation, however, was "myocardial damage, posterior damage" and later "healing posterior infarct."

Case 8.—L. W., a 78 year old woman, had a typical attack of pulmonary embolism on Sept. 14, 1950, two days after an operation for cataract, with dyspnea, shock, cyanosis, and arrhythmic tachycardia of 150; the next day there was a temperature of 102 to 103 F., and a clinical diagnosis of consolidation (pneumonitis) at the bases of both lungs was made. Phlebitis of the veins of the leg was noted eight days later. There was rapid clearing of symptoms and signs in the chest. The patient died twelve days later from cerebral thrombosis. At autopsy, embolism of the right lower pulmonary artery with an infarct at the base of the right lung plus a smaller infarct at the base of the left lung was noted.

The electrocardiogram of September 18 (fig. 5, case 8), four days after the acute embolism, showed:

1. Large S in leads 1 and 2.
2. Deep Q and diphasic T in lead 3.
3. Deep Q in AVF.
4. ST depressed in leads 1 and 2 and slightly elevated in lead 3.
5. Deep S through V-5 and V-6 and late R in AVR indicating clockwise rotation, unexpected in a horizontal heart.

The expected T inversion in the right precordial leads was absent here and made the differential diagnosis more difficult.

This case illustrates mainly the clockwise rotation of the electrical axis of the heart that occurs in pulmonary embolism, unusual ordinarily in a horizontal heart.

The electrocardiographic interpretation in this case was reported as "myocardial damage."

II. Suggestive Group, Five Cases

The electrocardiographic changes in this group were not in a complete and typical pattern. At least three or more abnormalities suggesting pulmonary embolism, however, were present in each case. The diagnosis in only 1 case (12) in this group was correctly interpreted as "suspected pulmonary embolism." The electrocardiographic diagnoses in the remaining 4 cases were: case 9, "no myocardial damage;" case 10, "disease of the coronary arteries, low physiologic tone, low T waves in the V leads;" case 11, "serious myocardial damage, left ventricular strain, no occlusion;" and case 13, "large anterolateral infarct."

It is in this group that the correct electrocardiographic diagnosis is missed most often. Perhaps a better understanding of the mechanism involved would help to identify these changes more correctly, even when they are not in a complete and typical pattern.

Table 1 contains a summary of the abnormalities in this group of cases, as to their frequency of incidence.

Table 1. — Electrocardiographic Abnormalities in Five "Suggestive" Cases of Pulmonary Embolism

Abnormalities	Cases	Case Numbers
Deep S in lead 1	2	11,13
Deep S in lead 2	3	9,11,13
Q in lead 3	2	10,12
Negative T in lead 3	2	9,12
Negative T in lead 2	1	11
ST depression in lead 1	2	11,12
ST depression in lead 2	3	9,10,11
ST elevation in lead 3	2	9,12
Deep S in left V leads (clockwise rotation)	5	9,10,11 12,13
Transient BBB or impaired intraventricular conduction	2	9,13
Right "ventricular strain" pattern T inversion in V-1, 2, 3, (4) or CF2, CF4	3	10,11,13
Rapid reversion to normal (in cases with serial EKG's)	2	9,11
Q in AVF	3	10,11,12
Flat to negative T in AVF	3	10,11,12
Late R in AVR	1	13
ST elevation in AVR	1	11

Obviously, the table cannot indicate the sense of the combination of the particular abnormalities encountered in each case.[3] As can be seen from the table, however, the most frequent combination was the one indicative of clockwise rotation of the electrical axis of the heart with shift of the transitional zone to the left. The most significant was a combination of abnormalities that might at first be suggestive of infarction of the posterior wall, associated with the right "ventricular strain" pattern of T inversion over the right side of the heart in V-2, 3, (4).

Case 9.—A. C., a 71 year old man, was in good health except for hypertension. Acute onset of pulmonary embolism occurred on July 28, 1950, with drop in blood pressure, nausea, epigastric pain and cough. A small area of density on the roentgenogram over the dome of the

right diaphragm, suggestive of atelectasis secondary to infarction, was clearing three days later and was all clear in eleven days. The clinical course was confirmatory.

The electrocardiogram of July 29 (fig. 6, case 9), one day after the attack, showed:

1. Deep S through V-6, indicative of pronounced clockwise rotation in a heart that was electrically horizontal in position, in the face of known long-standing hypertension.
2. Prolonged intraventricular conduction time with a QRS of 0.10 to 0.12 sec.
3. Deep S' in lead 2, negative T in lead 3, with ST depression in lead 2 and ST elevation in lead 3.

Case 10.—T. N., a 48 year old woman, had bleeding uterine fibroids, recurrent attacks of thrombophelebitis and two previous attacks of pulmonary embolism elsewhere. Typical clinical onset of pulmonary embolism occurred at 2 a.m., on Jan. 1, 1949, with shock, tachycardia, dyspnea, pallor, pain in the chest and bloody sputum the next day. Signs and roentgen findings were confirmatory. Rapid improvement and clearing of signs followed.

The electrocardiogram of Jan. 1, (fig. 6, case 10), twelve hours after the acute attack, showed only the following:

1. Broad q and flat T in AVF.
2. Flat T in the right precordial V leads through V-4.
3. Prominent S through V-6.

The clockwise rotation unexpected in a horizontal heart, and the flat T waves in the right precordial leads indicative of right ventricular strain, might have been considered suggestive of pulmonary embolism.

Case 11.—C. E., a 64 year old man, was under treatment for congestive failure and was fully digitalized. Acute onset of pulmonary embolism occurred nineteen days after admission, on April 18, 1950, with shock, and hiccup. Roentgen and clinical findings were confirmatory. Rapid improvement and clearing of signs followed.

The electrocardiogram of April 18 (fig. 6, case 11), twelve hours after the acute attack, showed:

1. Deep S through V-6. This was absent in a tracing taken eight days previously, indicating development of clockwise rotation since then.
2. T inversion in V-2 to V-5.
3. S deep in standard leads 1 and 2.
4. ST depression in leads 1 and 2, probably due to digitalis.
5. Q and negative T in AVF.

The sudden development of clockwise rotation of the electrical axis in a heart that was in a horizontal position, and the right ventricular "strain" pattern in the presence of a Q and negative T in AVF, might have been considered suggestive of pulmonary embolism.

Case 12.—E. M., a 35 year old woman, had an attack of pulmonary embolism on July 1, 1950, seven days after a second stage thoracic sympathectomy for malignant hypertension with blood pressure of 200/130. The clinical onset was typical with violent cough, shock, cyanosis, dyspnea, tachypnea and tachycardia. Moist basal rales and increased P-2 were noted the next day. The course was characteristic, with rapid clearing and recovery. The patient went home fifteen days after the attack and did well.

The electrocardiogram of July 3 (fig. 7, case 12), two days after the acute attack, showed:

1. Q and negative T in lead 3 and in AVF.
2. Deep S through V-5 and S in V-6.
3. ST depressed in leads 1 and 2, in V-6 and in AVL, probably due to digitalis.

There is no T inversion here in the right precordial V leads, and no S in leads 1 and 2.

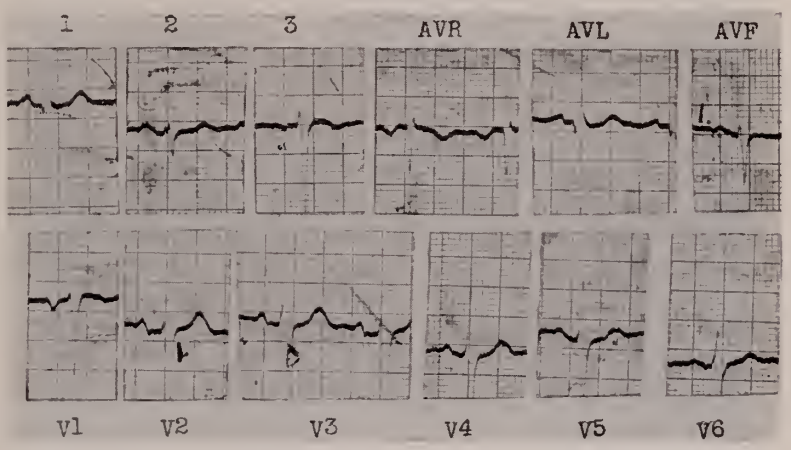


Fig. 6.—Case 9-7/29/50-Deep S through V-6, S-2, negative T-3, ST-2 down, ST-3 up, QRS 0.10 to 0.12 sec.

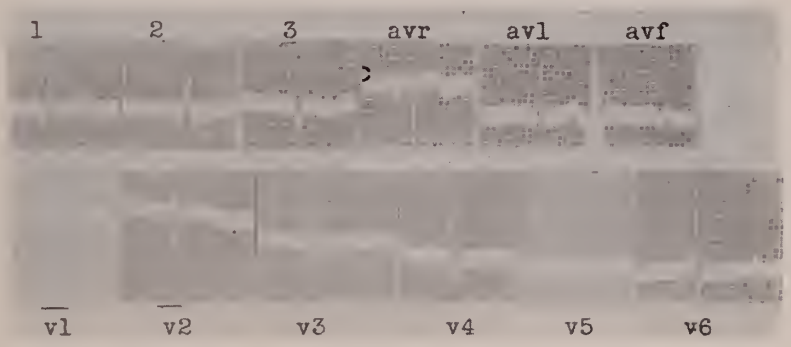


Fig. 6.—Case 10-1/1/49-Broad q and flat T in AVF, T flat in V-1-4, large S through V-6.

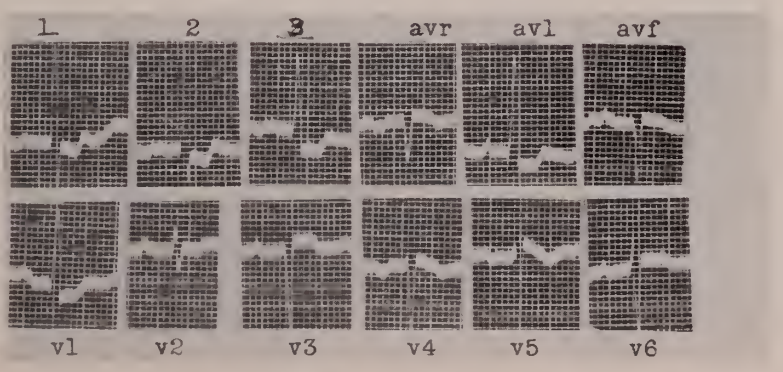


Fig. 6.—Case 11-4/18/50-Deep S through V-6, negative T in V-2 to V-5, S-1, S-2, ST-1 and ST-2 down, Q and negative T in AVF.

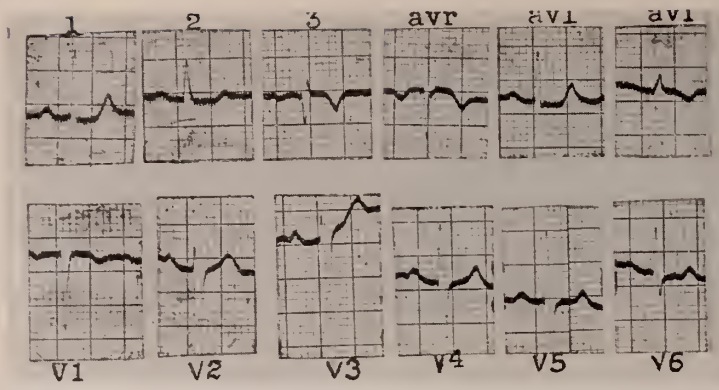
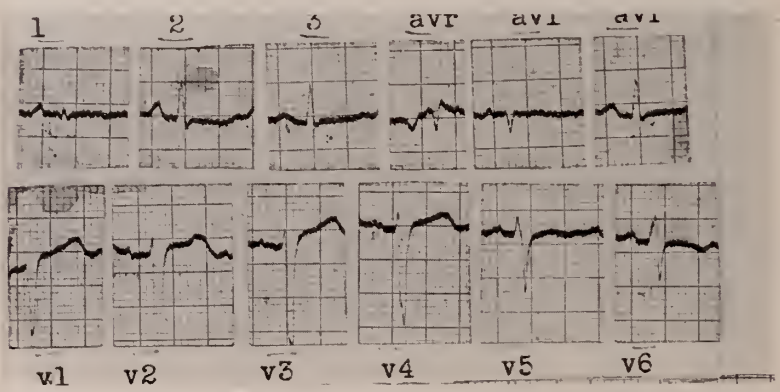
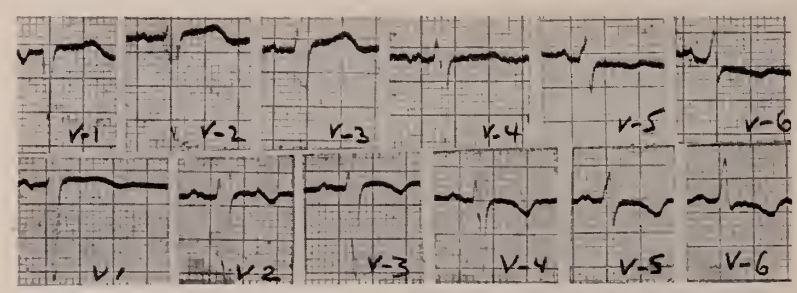


Fig. 7. — Case 12. Q-3, negative T-3, negative T in AVF, deep S through V-5, ST-1 and ST-2, and ST in AVL and ST in V-6 depressed.



Case 13. (A)—11/2/50—Small s-1, 2, 3, deep S in V-5, 6, T flat in 1, 2, 3, and AVL, negative in V-5, 6, widened QRS in V-2, 3.



(B)—11/4/50—S in V-6 less prominent, negative T in V-5, 6, more pronounced.

(C)—11/10/50—Negative T in all V leads.

The electrocardiographic interpretation in this case was correctly reported as "digitalis effect, myocardial damage, possible pulmonary embolus." The Q and negative T in leads 3 and AVF, associated with the tall upright T waves in the right-sided V leads might have warranted a diagnosis of infarction of the posterior wall. This case illustrates the difficulties in making a differential diagnosis between the two conditions.

Case 13.—W. F., a 53 year old man, had been in mild, untreated congestive failure, due to arteriosclerotic heart disease. There was a history of varicose ulcer of the leg, numerous sclerosing injections and unsuccessful venous ligation. Clinically typical onset of pulmonary embolism occurred on Nov. 2, 1950, preceded by cramps in the calf of the left leg earlier that day, with severe shock, cyanosis, transient loss of consciousness, tachycardia, and unobtainable blood pressure, followed next day by cough, bloody sputum and rales at the base of the right lung. The course was characteristic with rapid improvement, clearing of signs and recovery. The patient was discharged in nine days. The subsequent course was uneventful.

The electrocardiogram of November 2 (fig. 7, case 13A), twelve hours after the acute attack, showed:

1. Widened QRS in V-2 and V-3 with double peaking in some beats suggestive of right bundle branch block.
2. Deep S through V-5 and V-6 indicative of clockwise rotation.
3. Small s in leads 1, 2 and 3.
4. Flat T in leads 1, 2, 3 and AVL and inversion of T in V-5 and V-6.

No particular pattern could be elicited other than the suggestion of "myocardial damage."

The electrocardiogram of November 4 (fig. 7, case 13B), two days later (V leads only), showed:

1. S in V-6 less prominent.
2. T inversion in V-5 and 6 more pronounced.

The electrocardiogram of November 4 (fig. 7, case 13C), eight days later, showed:

1. T inversion in all the precordial leads, (as well as in the standard leads).

III. Atypical Group, Eight Cases

The electrocardiographic findings in this group showed no recognizable pattern in any way suggestive of a possible diagnosis of pulmonary embolism. In 5 of the 8 cases antecedent myocardial infarction served to distort the picture. In the remaining 3 cases the embolism was mild, transient and apparently not severe enough to cause any electrocardiographic changes at all.

Case 14.—T. McK., a 62 year old man admitted on Oct. 9, 1950, had had two known previous myocardial infarcts, one anterior and one posterior. While under treatment for congestive failure, he sustained a severe and clinically typical attack of pulmonary embolism associated with pleural effusion. Paracentesis yielded bloody fluid. He died one year later, and an old pulmonary infarct was found at autopsy.

The electrocardiogram of October 10, one day after the attack, failed to show any change that could be attributed to the pulmonary embolism. The antecedent tall T waves in the right-sided V leads, due to the previous posterior infarction, may have obscured the T inversion that the pulmonary embolism might have caused.

Case 15.—T. J., a 38 year old man, had a clinical onset and course not typical of pulmonary embolism; rather, it was one of left ventricular failure with acute pulmonary edema. Autopsy showed two old myocardial infarcts

(seven months old) as well as fresh infarcts of the upper lobe of the right lung.

An electrocardiogram, two days after the attack, showed the residuals of the previous anteroseptal infarction. The precordial T waves, however, which in an old tracing were upright, were now negative in V-1 to V-4.

Cases 16 and 17.—M. T., a woman aged 77, and F. B. M., a man aged 75, both had severe antecedent myocardial damage with multiple infarcts and pronounced residual T inversion throughout the electrocardiogram. The superimposed pulmonary embolism was obscured by these preexisting abnormalities. There were no typical or even suggestive changes of pulmonary embolism.

Case 18.—F. G. K., a 43 year old man, had an antecedent infarction of the posterior wall with residual Q and negative T in leads 2 and 3. In the precordials CF-2, CF-4 and CF-5 there were tall upright T waves. The superimposed fatal pulmonary embolism did not alter these changes to an extent sufficient to be identifiable.

Cases 19, 20 and 21.—In these 3 cases the condition was mild and transient. In 2, the pulmonary embolism occurred postoperatively, in 1 with transient fibrillation. In none of them did the electrocardiogram reveal any significant abnormalities.

I should like now to review briefly the mechanism causing the electrocardiographic changes in pulmonary embolism and the criteria presently accepted as typical.

Table 2. — Mechanism of Electrocardiographic Changes in Pulmonary Embolism

1. Myocardial Anoxia (Ischemia)
   - A. Reflex coronary vasoconstriction
   - B. Shock, drop in aortic blood pressure, diminished coronary blood flow
2. Acute Cor Pulmonale
   - A. Reflex pulmonary arteriolar vasoconstriction
   - B. Acute pulmonary hypertension
   - C. Acute increase in right intraventricular pressure
     - (1) Decrease in pressure gradient of blood flow to the right ventricle
     - (2) Dilatation and strain of the right ventricle and conus
     - (3) Increased work by the right ventricle
3. Changes in Electrical Position of the Heart
   - A. Clockwise rotation about long axis with shift of transitional zone to the left
   - B. Clockwise rotation about anteroposterior axis into more nearly vertical position.
4. Transient Right Bundle Branch Block

Mechanism[1,5,6,10,11]

The electrocardiographic changes of pulmonary embolism (table 2) are caused by:

1. Myocardial anoxia (ischemia) due to
   - A. Reflex coronary vasoconstriction resulting from the obstruction of a large branch of the pulmonary artery by an embolus. The existence of such vasovagal reflexes has been demonstrated experimentally.
   - B. Shock and drop in aortic blood pressure resulting in direct diminution of coronary blood flow.
2. Acute cor pulmonale resulting from
   - A. Reflex pulmonary arteriolar vasoconstriction in response to occlusion of a large branch of the pulmonary artery. It is conceivable that smaller emboli may fail to set up an intense enough reaction and therefore fail to cause significant electrocardiographic changes.
   - B. Acute pulmonary hypertension due to the vasoconstriction in the pulmonary circuit.
   - C. Sudden acute increase in right intraventricular pressure. This in turn causes:
     - (1) Decrease in the pressure gradient of blood flow to the right ventricle because 92 per cent of the venous return from it empties directly into the right ventricular chamber through the Thebesian veins.
     - (2) Dilatation and "strain" of the right ventricle and pulmonary conus with shift of the septum to the left.
     - (3) Increased work by the right ventricle in the face of a diminished blood supply.

     This process results in electrocardiographic changes confined mainly to the ST segment and T wave. It also causes:
3. Changes in the electrical position of the heart. The heart becomes rotated clockwise about both the anteroposterior and long axes, in such a way as to bring the right ventricle more anteriorly and to the left and place the heart in a more nearly vertical position. This rotation manifests itself in the electrocardiogram as a shift of the transitional zone to the left, with deep S waves as far as V-5 and V-6, in AVL, and in lead 1. It also causes a late R in AVR.
4. Transient right bundle branch block, a frequent result of the right ventricular ischemia, hypertension, dilatation and strain.

Not all of the components of this mechanism operate in every case. There are, therefore, variations from case to case.

Because reflex phenomena play a major role in this mechanism, the changes resulting from them are transient. This is one of the most notable characteristics of the electrocardiographic changes in pulmonary embolism — that they are transient and may revert to normal in a few days or even hours.

Table 3.—Diagnostic Criteria of Pulmonary Embolism

1. Standard Leads
   - Deep S-1, (or S-1 and S-2)
   - Prominent Q-3
   - ST-1 and ST-2 depression
   - ST-3 elevation
   - T-2 low, flat or diphasic
   - T-3 inverted
2. Precordial V Leads and AV Limb Leads
   - T inversion in V-1, 2, 3, (4)
   - Rapid reversion of negative T in V leads to normal
   - Deep S waves in V-4, 5, (6) and AVL
   - Transient right bundle branch block
   - Late r or r′ in AVR

The Diagnostic Criteria of Pulmonary Embolism (Table 3)[1,2,6,7,10,11]

I. In the standard leads

1. Deep S in L-1 (or L-1 and L-2)
   This S may be large and broad and suggestive of complete, or incomplete right bundle branch block.
2. Q present and prominent in L-3.
3. ST segment depressed in L-1 and L-2, with a steplike ascent.
4. ST segment elevated in L-3.
   The ST segment may often be short so that the T comes off directly from the QRS complex.
5. T is lowered, flattened or diphasic in L-2.
6. T is inverted in L-3.
   Items 1, 2 and 6 are the S-1Q-3 negative T-3 complex of McGinn and White.

II. In the precordial and AV limb leads

1. Consistent sharp inversion of the T waves in the V leads over the right precordial area — in V-1, 2, 3, (4).[2,11]
   This represents the so-called right "ventricular strain" pattern. Inverted T's may appear in all the V leads, but they appear first, and are most pronounced over the right side of the heart. They may not be reflected to the limb leads and therefore do not show up in the standard leads.
   In those cases in which there is not enough clockwise rotation of the heart to cause much change in the limb and standard leads, the T inversion in the right-sided V leads may be the only abnormal finding present.
2. Rapid reversion of the inverted T waves in the V leads to normal. This may occur within a short time, sometimes in only a few days. The inverted T waves in the V leads may become upright, usually first over the left ventricle and last over the right in V-1, 2, 3, (4).
3. Shift of the transitional zone to the left. This is due to the clockwise rotation causing the presence of deep S waves over the left precordium in V (4), 5, 6, and in AVL. This contributes to the formation of the prominent S in standard lead 1.
4. Transient right bundle branch block or delayed intraventricular conduction, with prolongation of the QRS interval and a late r′ or R′ in the right-sided V leads (V-1, 2).
5. Later R or R′ in AVR.
   This is also due to the clockwise rotation causing AVR to face the back of the heart. According to Goldberger,[10] it is due to the dilatation of the pulmonary conus as well. Right bundle branch block when present can also cause it. This late R or R′ contributes to the formation of the deep S in lead 1 (because L-1 is the reverse of AVR).
6. ST segment depression in the V leads and in AVL.
7. Elevation of the ST segment in AVR.
   This is due to myocardial anoxia as well as to the right "ventricular strain." It is often associated with:
8. Disappearance of the normally negative T in AVR.
9. Q and negative T in AVF are not characteristic findings, but occur often enough to cause confusion in the differential diagnosis from infarction of the posterior wall.

Differential Electrocardiographic Diagnosis Between Pulmonary Embolism and Posterior Wall Myocardial Infarction[2,6,11]

Both pulmonary embolism and posterior wall infarction can cause many of the changes listed, especially in the standard leads. Both can cause ST elevation in L-3, ST depression in L-1, in the V leads, and in AVL, Q-3, negative T-3, and Q and negative T in AVF. As a result, the changes may closely resemble each other and are often difficult to tell apart in a given single tracing; however,

there are some important differences (table 4):

1. S-1:
   It is most unusual to find a large S-1 in posterior infarction. In pulmonary embolism it is common.
2. Q-2, Q-3:
   In posterior infarction there is usually a Q in lead 2 as well as in lead 3. In pulmonary embolism there is usually no Q in lead 2.
3. ST-2 elevation versus depression.
   In posterior infarction ST-2 is usually elevated.
   In pulmonary embolism ST-2 is usually depressed.
4. Negative T-2, T-3.
   In posterior infarction T tends to be inverted both in lead 2 and lead 3. In pulmonary embolism T-2 tends to be lowered, flat, or diphasic, but is not characteristically inverted.
5. Rapid reversion versus progression.
   In pulmonary embolism the electrocardiographic changes are transient and revert to normal rapidly. In myocardial infarction the changes last longer and go through typical serial progression in successive tracings.
6. Sharp T inversion in V-1, 2, 3, (4) with rapid reversion to normal. This is the most important differential finding between the two. In pulmonary embolism it is the most important and consistent finding, representing the right "ventricular strain" pattern of cor pulmonale. In posterior infarction the exact opposite obtains. Here the T waves in the right-sided V leads are either normal or are reciprocally elevated and increased in amplitude in V-1, 2, 3, (4).

Anteroseptal infarction and digitalis can also cause T inversion in the right-sided V leads, V-1,-2, 3, (4). In the case of digitalis, the contour of the depressed ST segment here, as well as in the other leads, helps. In anteroseptal infarction the rotation of the heart is more likely to be counterclockwise rather than clockwise. The associated Q waves make the diagnosis.

Summary and Conclusions

A series of 21 cases of pulmonary embolism is reported in three groups, illustrating typical, suggestive and atypical electrocardiographic changes. The mechanism causing these changes, the diagnostic criteria and the differential electrocardiographic diagnosis between pulmonary embolism

Table 4.—Electrocardiographic Differences Between Pulmonary Embolism and Posterior Wall Infarction

	Pulmonary Embolism	Posterior Wall Infarction
Q-2	Q-2 may occur, but is uncommon	Q-2 is usual
Q-3	Present in both	
Q in AVF	May be present in both	
S-1	Deep and broad, is characteristic	Prominent S-1 not common
ST-1	Depressed in both	
ST-2	Depressed with steplike accent	Usually elevated
ST-3	Elevated in both	
ST in V leads and AVL	May be depressed in both	
T-2	Rarely inverted, may be low, flat or diphasic	Usually inverted
T-3	Inverted in both	
T in V-1,2, 3,(4)	Typically inverted	Typically up and reciprocally tall
Clockwise rotation (shift of transitional zone to left)	Typically present	Typically absent and is most unusual (unless anterior infarction is also present)
Late R in AVR	Typical	Rare
Progression	Rapid reversion to normal of some or all of these changes, particularly the rotation and T inversion in V-1,2,3,(4)	Typical progression of changes in serial tracings over period of weeks to months

and myocardial infarction of the posterior wall are reviewed.

Typical electrocardiographic changes of pulmonary embolism in complete combination occur in a minority of cases. No single abnormality is consistently present; however, in a considerable number of cases the findings are strongly suggestive of the mechanism as described, the most important of these being a combination of changes suggesting infarction of the posterior wall associated with the right ventricular strain pattern and pronounced clockwise rotation.

The severity and magnitude of the pulmonary infarction do not necessarily run parallel with the extent of electrocardiographic change and cannot be estimated from it. In milder cases, however, the smaller emboli may fail to cause any recognizable electrocardiographic changes.

When there are antecedent coronary disease and insufficiency, pulmonary embolism can cause enough myocardial anoxia to result in an electrocardiogram showing only disease of the coronary arteries. When there are antecedent myocardial infarcts, their electrocardiographic abnormalities obscure those of the superimposed pulmonary embolism and make it difficult or impossible to recognize them.

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Citizens Building.

Medical Ethics of Today

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Doctors of Medicine, let us today rededicate ourselves to the proposition that in a great measure human health and happiness — yes, even existence — depend upon our thoughts and actions. This fundamental tenet of our profession has not changed since that greatest Healer of all time gave his life that others might live. The effectiveness of this proposition is compellingly reflected today through the magnitude of our innumerable devices in prolonging the span of life, and, as a corollary, increasing happiness. This inventory of correct principles of conduct between ourselves and the public has been going on since the first medicine man began studying the other fellow. Today I hope it culminates not so much in a conviction of sin or a recognition of danger as in an appreciation of the responsibility of our position. Personally, I find the responsibility tremendous, for I fully realize this gesture voices judgment of the most responsible group in the world.

In the beginning of this short talk I should like to reiterate the modernization of the Hippocratic Oath, known as the Declaration of Geneva 1948:

> Now being admitted to the profession of Medicine, I solemnly pledge to consecrate my life to the service of humanity. I will give respect and gratitude to my deserving teachers, I will practice medicine with conscience and dignity. The health and life of my patients will be my first consideration. I will hold in confidence all that my patient confides in me. I will maintain the honour and noble traditions of the medical profession. My colleagues will be as my brothers. I will not permit consideration of race, religion, nationality, party politics or social standing to intervene between my duty and my patient. I will maintain

Read before the Florida Chapter of the American Academy of General Practice, Second Annual Fall Meeting, Ocala, Oct. 14, 1951.

the utmost respect of human life from its conception. Even under threat I will not use my knowledge contrary to the laws of humanity. These promises I make freely and upon my honour.

In discussing "The Physicians' Responsibility" in the April 1951 number of the Journal of the Medical Association of Georgia, Dr. A. M. Phillips reminds us of a further obligation:

> We owe it to our patients to keep our skill at its peak by practicing, in our own expenditure of physical and mental energy, the moderation which we preach to them, and by utilizing the cultural and spiritual resources afforded by wholesome recreation, reading, home life, and worship. An extensive practice is exhausting; and when we become overtaxed our medical judgment wavers, our patients are denied their rightful consideration, and we become guilty of that assembly-line type of treatment which we so greatly deplore in England.

To render the greatest and most efficient service possible first requires thorough training on our part, and ever thereafter continued, competent training, as the study of medicine is for keeps. An explanation for increased specialization is the instinctive desire to do our utmost in striving for perfection. I have no uneasiness about the present controversy of specialist versus general practitioner. The fundamental truth is that both have a place in the sun, and, as usual, the laws of supply and demand will swing the pendulum to a proper proportion of each to fit the public needs. Each group is essential to the other, and the general practitioner no more desires condescension and flattery than the specialist deserves praise and adulation.

It has been said that the minds of men are held in bondage by the cardinal sin of certitude. Even with the rapid advancement of medicine today, there is yet present much of that drag on modern progress.

Teaching the medical teacher in the fundamentals of delivery and rhetoric is as much to be desired as competency in research, and, of necessity, the successful teacher must not only possess these attributes but be an excellent clinician as well. We must of course give the best in medical instruction, but we must also educate in the widest sense, for physicians now more than ever before must compare favorably with the members of other highly trained professions. In particular, I refer to a lack of interest in and aptitude for the preparation of scientific, political and community interest presentations, which are essential if we are to keep abreast of the broad aims of making Doctors of Medicine leaders in their communities.

Yes, we should be good doctors first and always. Today, however, we must have the know-how to run efficiently a business office, knowledge of the Treasury Department's requirements as to deductible and nondeductible items, knowledge of social security and withholding taxes, knowledge of proper licensure, and knowledge that will serve as a broad guide to the new doctor in his selection of a locality and in getting established. Detailed instructions on these and many other phases of inter-relation medical ethics are fully outlined in "The Doctor" by Dr. Stanley R. Truman, published in 1951 by the Williams and Wilkins Company of Baltimore.

Organization

Naturally, one of the new physician's first acts is to align himself with the medical societies in his community and to go all the way through to the national levels. Only by organization can we obtain the necessary self improvement these bodies furnish. Thus, we learn to work with each other and for the public good, and to attain leadership and prestige in the public esteem.

The current united efforts of the medical profession have definitely slowed the Washington urge for the socialization of medicine. Contemplate your heroic work here in this state which was instrumental in expelling from Washington one of socialization's staunchest adherents. How well Benjamin Franklin's famous remark sums up our situation: "We must all hang together or we will hang separately."

In our zeal for organization, however, we are now encumbered by a myriad of meetings, conventions and conferences. These, I believe, should be streamlined and consolidated to conserve our time in the best interests of the public good.

Never must we neglect cordial and genuine relations with our strong allies, the dentist and the druggist. They are part and parcel of the same effort to heal the sick which engages us.

Our indispensable tool, the hospital, is now receiving much public disfavor because it is, in a measure, practicing medicine, and in effect running our business for us in its own way. This charge is serious and must be squarely met, for if physicians cannot practice medicine in the right way, their way, with their leadership, I pledge you the government will then take over the practice of medicine.

It would seem that now in all the world only one person is to be trusted — the Doctor. From the cradle to the grave, one calls continually upon him to testify. Not only does he attest one's advent into this world, but, once here, the individual

may not get married, get a job, change a job, leave the country, get insurance and meet a host of other can'ts and don'ts until he has the sanction of the doctor. Finally, he cannot even leave this mundane sphere until the doctor certifies for him that last passage west, and furthermore testifies as to what took him on that journey from which there is no return.

Insurance

Life is getting more complicated all the time. Its growing intricacies naturally suggest a brief discussion of the multitudinous insurance forms confronting us, which daily increase in volume and complexity. The best answer that I would have to this vexing problem is to hire a smart girl, for we can at least learn to sign our name on the right line. Seriously, however, this is a part of our life now. The man who is drawing compensation may have to feed a large family of children, and unless we promptly and cheerfully fill out his blanks, we give medicine a black eye. I think you get the hint about public relations with this pointed reminder.

Again, in the same vein, we doctors who have worked hard and rightfully for voluntary health insurance plans can be part of a conspiracy to wreck them. To do so is easy; only the doctor, the policy owner-patient and the hospital need connive, and the wreck will be quickly accomplished and fatal.

In all earnestness, I appeal to every member of the medical profession to be ever mindful that success or failure of voluntary health insurance lies in our hands. Do we want socialization of medicine? Then all we need do is to wreck the voluntary health insurance plans. To avoid such a catastrophe, how can we help the voluntary health plans to succeed? As general practitioners who handle the great bulk of insurance work, we especially owe it to our public that false statements as to present and past health are not concealed in the quest of something for nothing. Likewise, admissions and discharges, diagnostic, x-ray and laboratory work, as well as excessive hospital days, transfusions, medicines and the like, as a matter of convenience, are to be condemned.

The nub of the matter here is the necessity for which the reserves are set. Destroy needlessly this balance, and you jeopardize your future as a physician with freedom of choice in your hands. As physicians we have offered the public voluntary health plans as an alternative to compulsory health insurance. These plans cannot be as lucrative as investments in a similar field. If any company vitiates our intent honestly to protect its clients, then it is our plain duty, through the American Medical Association, to give our approval to the operation needs as we approve medical schools or drugs today.

Other Needs

The need for more and better nurses, as well as medical students, is apparent to all, as are more and better hospitals and allied appurtenances. None of these are to be obtained by wishful thinking or gullible promises from political aspirants with the proverbial axe to grind.

My friends and colleagues, we are going about this complicated problem the honest way. The medical profession through properly organized channels is making real sacrifices monetarily and by the sweat of the brow to promote and finance all of these needs, and more, that none should be lacking in proper medical care.

Truthfully, we can point to the irrefutable fact that we are the healthiest nation in the world. By our self-supporting attitude we are making the American public our staunch ally, as self reliance and individual thinking are distinctly American ways of life.

In conclusion, I could not do better in summarizing the main aspiration of medical ethics today than to quote from an address by Mr. Bernard M. Baruch:

> What is this adventure in health I see dawning, and towards which you all have been keeping the doctor's vigil through the night? This adventure, which you will have to lead — or it will fail — has many elements:
>
> 1. More and better doctors — in more places.
> 2. An immediate, complete survey to modernize medical education, with greater emphasis on chronic and degenerative diseases, mental hygiene, and preventive medicine.
> 3. More hospitals more evenly spread through the country.
> 4. Less specialists, more general practitioners.
> 5. Reorganize medical practice, stressing group medicine where needed and voluntary health insurance.
> 6. For those who cannot afford voluntary insurance, some form of insurance partly financed by the Government, covering people by law. I would call this "compulsory health insurance," if that term's proper meaning has not been lost.
> 7. Increased medical research.
> 8. Greatly expanded physical and mental rehabilitation.
> 9. Education to make health a national habit.
> 10. A vigorous, preventive medical program, reaching everyone, children above all.
> 11. A new cabinet post for health, education, social security.
> 12. Creation of a nonpolitical, watchdog committee to safeguard progress in medical care for veterans.

13. Increased numbers of well trained nurses and technicians.

14. Adequate dental care.

15. A stabilizing economy — inflation will make worthless any health program or anything else.

For your serious thought and consideration, I would leave with you these three questions:

1. Are the doctors going to do the practicing of medicine in the future?

2. Are the hospitals going to do the practicing of medicine in the future?

3. Is the government going to do the practicing of medicine in the future?

We of the medical profession now have the leadership. Let us make sure that we keep it and make the most of it. To do so — get in and pitch!

225 West Ashley Street.

Routine Laboratory Determinations in "Organic" Versus "Functional" Disease: Study of Two Hundred and Eleven Unselected Office Patients In An Internist's Practice

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and
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Miami

This paper presents objective evidence that physical abnormality can be found in a significant majority of medical patients, regardless of whether their symptoms appear "functional" or "organic" by usual clinical criteria. This is not consistent with current medical opinion, which estimates that one third to two thirds of all medical patients present primarily functional problems and thereby have no demonstrable physical basis for their complaints.[1]

Contained in this report are the results of a study of 211 unselected patients seen in the private practice of an internist in Miami between June 1, 1950 and June 1, 1951. All of these patients had at least one characteristic in common: they had symptoms which had caused them to consult a physician for relief. Patients simply seeking a "routine check-up" were not included. A parallel group of 21 "normal" controls was composed of volunteers who believed they were in good health and were certain that they did not require medical care. Excluded from this group of "normals" were any who did not pass a simple verbal screening test to minimize the likelihood of a need for medical aid and the possible existence of chronic subclinical sequelae to some acute disease suffered in the past (table 1).

From the Medical Research Unit, University of Miami, Miami, Fla.

Method

On the basis of history and physical examination, without consideration of laboratory findings, each patient was placed in one of three general categories: (1) Symptoms mainly due to "organic" disease. There were 65 subjects in this group, 24 males and 41 females. Ages ranged between the extremes of 13 and 80. Table 2 shows the age distribution, by decades, in this group as well as in the other groups. Table 3 is a list of the various diagnoses made in this group. The occurrence of multiple diagnostic entities in some patients caused the number of diagnoses to exceed the number of subjects in this group and in the following groups. (2) Symptoms due to "functional" problems superimposed upon obvious "organic" disease. Despite the presence of definite organic disease in this group of patients, their principal complaints were judged to have an appreciable "functional" component by usual clinical criteria. There were 53 subjects in this group, 22 males and 31 females. Ages ranged between the extremes of 15 and 75 years. Tables 4 and 5 are lists of the various "organic" and "functional" diagnoses made in this group of patients. (3) Symptoms primarily due

Table 1. — Criteria For Selection Of Normal Controls

No subject to be included who answers question 1 or 9 in the negative or any of the other seven questions in the affirmative.

1. Are you in good health as far as you know?
2. Have you had any illnesses, even a cold, during the past month?
3. Do you tire easily?
4. Are you very nervous?
5. Do you suffer from stomach trouble, constipation, gas, headaches, dizziness, palpitation or shortness of breath?
6. Have you ever had any serious illness, such as rheumatic fever, tuberculosis, malaria, nephritis, osteomyelitis, poliomyelitis, hypertension, jaundice, infectious mononucleosis or scarlet fever?
7. Have you suffered from allergic conditions such as asthma, hay fever or hives during the past year?
8. Have you had any operations or serious injury during the past year?
9. Do you sleep well?

Table 2. — Age Distribution by Decades

Group Number	Ages in Years	Male	Female	Total
1. "Organic"	10-19	1	3	4
	20-29	1	8	9
	30-39	3	4	7
	40-49	2	5	7
	50-59	9	9	18
	60-69	8	9	17
	70-79	1	1	2
	80-89	0	1	1
		25	40	65
2. "Organic" plus "functional"	10-19	0	1	1
	20-29	1	8	9
	30-39	5	4	9
	40-49	3	7	10
	50-59	9	8	17
	60-69	2	3	5
	70-79	1	1	2
	80-89	0	0	0
		21	32	53
3. "Functional"	10-19	0	1	1
	20-29	7	10	17
	30-39	14	22	36
	40-49	6	15	21
	50-59	2	10	12
	60-69	1	4	5
	70-79	0	1	1
	80-89	0	0	0
		30	63	93
4. "Normal" controls	10-19	0	1	1
	20-29	6	7	13
	30-39	2	0	2
	40-49	4	0	4
	50-59	0	0	0
	60-69	0	0	0
	70-79	1	0	1
	80-89	0	0	0
		13	8	21

Table 3. — Diagnoses in Patients With Symptoms Mainly Due to Organic Disease

Diagnosis	Cases
Arteriosclerotic heart disease	19
Chronic rheumatic heart disease	10
Hypertensive heart disease	8
Subacute virus infection	6
Chronic rheumatoid arthritis	4
Diabetes mellitus	3
Pregnancy	3
Chronic infectious mononucleosis	3
Hypertensive vascular disease	3
Chronic sciatic neuritis	2
Acute virus upper respiratory infection	2
Chronic viral hepatitis	2
Thyroid adenoma	2
Peptic ulcer	2
Chronic bursitis	1
Hyperthyroidism	1
Buerger's disease	1
Carcinoma of the bladder	1
Syphilitic heart disease	1
Hypothyroidism	1
Acute virus gastroenteritis	1
Brain tumor	1
Acute brachial neuritis	1
Subacute cholecystitis	1
Infectious polyarthritis (tuberculosis, arrested)	1
Amyotrophic lateral sclerosis	1
Cerebral arteriosclerosis	1
Chronic phlebitis	1
Cirrhosis of the liver	1
Disseminated lupus erythematosus	1
Multiple sclerosis	1
Latent tertiary syphilis	1
	87

Table 4. — Organic Diagnoses in Patients With Functional Symptoms Superimposed on Underlying Organic Disease

Diagnosis	Cases
Arteriosclerotic heart disease	18
Chronic rheumatic heart disease	7
Hypertensive heart disease	6
Chronic bronchitis	3
Peptic ulcer	3
Acute virus upper respiratory infection	2
Pregnancy	2
Pulmonary emphysema	2
Acute sciatic neuritis	2
Subacute virus infection	2
Chronic pelvic inflammatory disease	1
Chronic prostatitis	1
Hypothyroidism	1
Latent tertiary syphilis	1
Chronic intercostal neuritis	1
Spontaneous pneumothorax	1
Chronic rheumatoid arthritis	1
Subacute cystitis	1
Chronic infectious mononucleosis	1
Cirrhosis of the liver	1
Chorea	1
Chronic ulcerative colitis	1
Subacute bursitis	1
Hypertensive vascular disease	1
Parkinsonism	1
	62

Table 5. — Functional Diagnoses in Patients With Functional Symptoms Superimposed on Underlying Organic Disease

Diagnosis	Cases
Anxiety state, anxiety neurosis	28
Neurasthenia	19
Spastic colitis, irritable bowel syndrome	6
Reactive depression	3
Bronchial asthma	3
Hypochondriasis	2
Atopic dermatitis, neurodermatitis	1
Migraine headache	1
Chronic alcoholism	1
Tension headache	1
Neurocirculatory asthenia	1
	66

Table 6. — Diagnoses in Patients With Symptoms Primarily Due to Functional Problems

Diagnosis	Cases
Neurasthenia	37
Anxiety state, anxiety neurosis	23
Neurocirculatory asthenia	13
Reactive depression	11
Atopic dermatitis, neurodermatitis	11
Hypochondriasis	5
Vasomotor rhinitis	5
Spastic colitis	5
Migraine headache	3
Globus hystericus	3
Narcolepsy	1
Peptic ulcer syndrome	1
Tension headache	1
Paroxysmal tachycardia	1
Histamine headache	1
Mucous colitis	1
Pylorospasm	1
Bronchial asthma	1
Tic douloureux	1
	125

to "functional" problems. Patients in this group had no evidence of "organic" disease. Table 6 is a list of the diagnoses among these patients. There were 93 subjects in this group, 30 males and 63 females. Ages ranged between the extremes of 17 and 70 years.

There were 21 "normal" controls, 13 males and 8 females. Their ages ranged between 19 and 78 years.

Laboratory Examination. A urinalysis, complete blood count, erythrocyte sedimentation rate (Wintrobe, corrected), and cephalin flocculation test were performed on each subject. Each smear for differential count was carefully examined for the atypical lymphocytes and monocytes with vacuolated basophilic cytoplasm and fenestrated nuclei found in chronic infectious mononucleosis[2] and chronic viral hepatitis.[3] Two hundred leukocytes were counted each time such an examination was performed.

Individual laboratory determinations were considered abnormal in accord with the following criteria:

1. Sedimentation Rate: More than 12 mm. hr., after correction for hematocrit.
2. White Blood Count: Less than 5,000 or more than 10,000 per cubic mm.
3 Relative Lymphocyte Count: Percentage of lymphocytes above 38 per cent or below 20 per cent.
4. Atypical Lymphocytes and/or Monocytes: Presence of any such cells on examination of 200 leukocytes during course of differential count.
5. Cephalin Flocculation Test: At least 2 plus in twenty-four hours and at least 3 plus in forty-eight hours.

Results

A summary of the laboratory findings in the four groups of subjects is presented in figure 1.

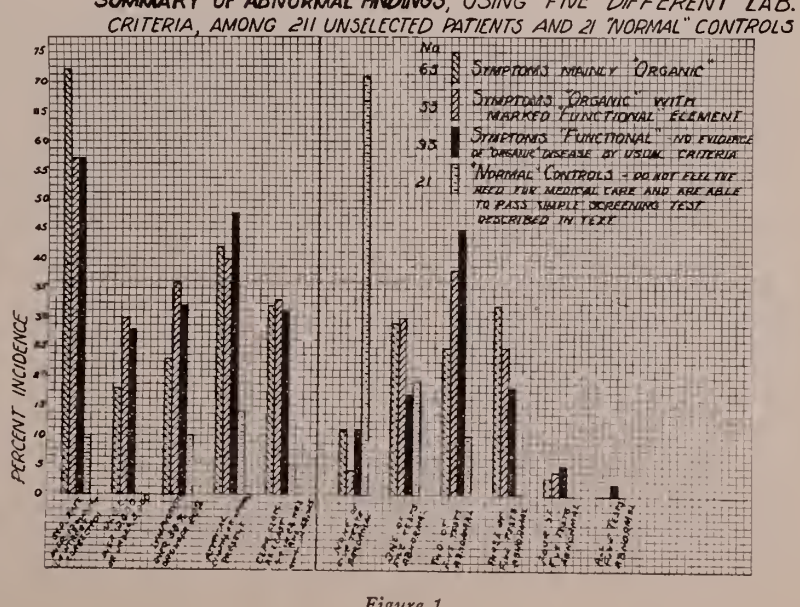


Figure 1

Sedimentation Rates. Sedimentation rates were elevated above 12 mm./hr. in 2 of the normal controls, an incidence of 9.6 per cent. A majority in each of the three groups of patients had abnormally elevated sedimentation rates. In group 1 ("organic" disease), the incidence of abnormal elevation was 72 per cent, in group 2 ("organic" disease with superimposed "functional" symptoms) 57 per cent and in group 3 ("functional" disease) 57 per cent. Figure 2 shows the relative distribution of sedimentation rates in each of the four groups.

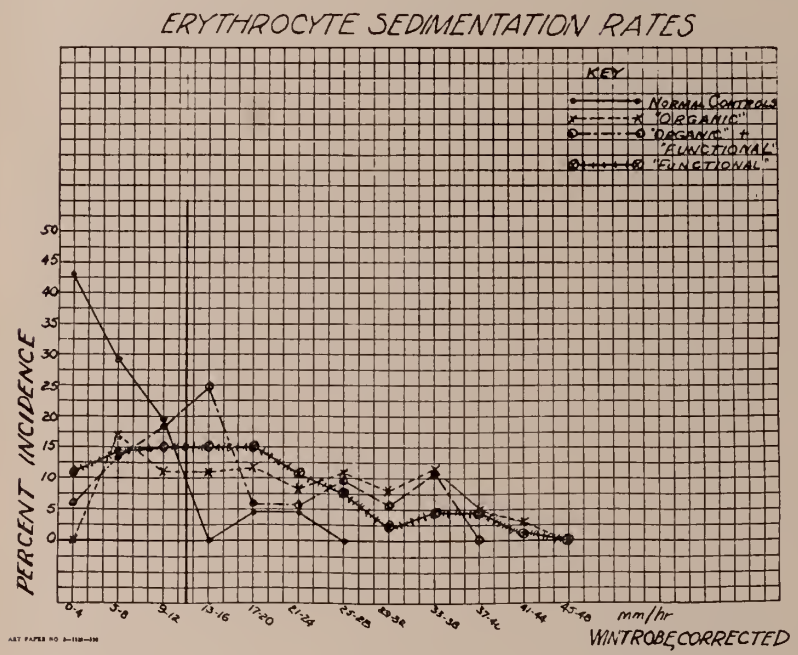


Figure 2

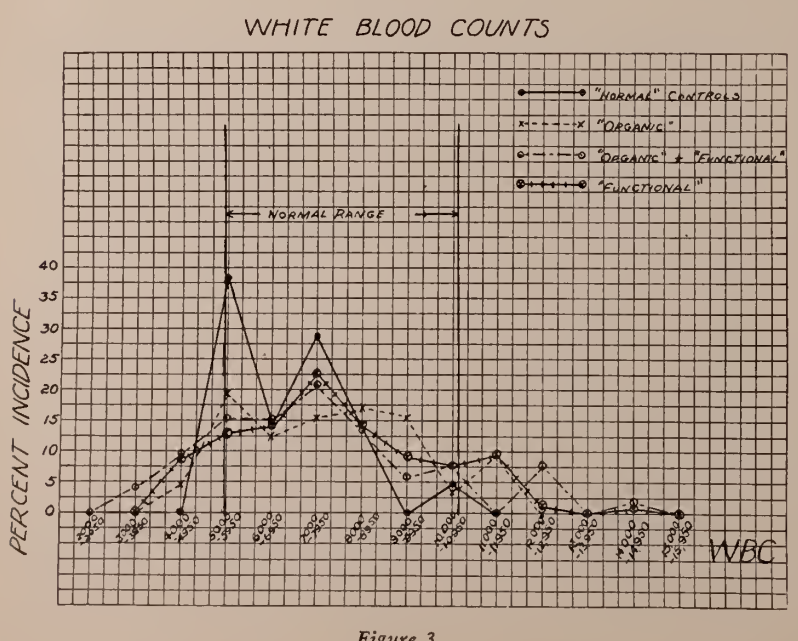


Figure 3

White Blood Counts. None of the normal controls had a count of less than 5,000 or more than 10,000. In patient groups 1, 2 and 3, the incidence of abnormally high plus abnormally low counts was 18 per cent, 30 per cent, and 28 per cent, respectively. Figure 3 shows the relative distribution of leukocytosis and leukopenia among the four groups of subjects.

Relative Lymphocyte Counts. Lymphocyte counts of more than 38 per cent were found in 2 of the normal controls, an incidence of 9.6 per cent. None of the normal controls had counts below 20 per cent. In patient groups 1, 2 and 3, the incidence of counts over 38 per cent or under 20 per cent was 23 per cent, 36 per cent and 32 per cent, respectively. Figure 4 shows the relative distribution of lymphocytosis in each of the four groups.

Atypical Lymphocytes and/or Monocytes. Atypical cells were found in 3 of the normal controls, an incidence of 14 per cent. The incidence of blood smears which showed these cells in the three groups of patients was 42 per cent, 40 per cent and 48 per cent, respectively. When atypical cells were found, they were present in concentrations varying from 0.5 to 10.0 per cent, which is comparable to the incidence of these cells reported by Isaacs[2] in chronic infectious mononucleosis. Figure 5 shows the relative percentage of atypical cells present in each of the four groups.

Cephalin Flocculation Tests. There was 1 positive reaction to the cephalin flocculation test among the 21 normal controls, an incidence of 4.8 per cent. In the three groups of patients, the incidence of positive reactions was 32 per cent, 33 per cent and 31

per cent, respectively. Figure 6 shows the relative distribution of degrees of positivity in this test in the four groups after twenty-four and forty-eight hours.

Distribution of Abnormal Findings Among Various Age Groups. It was thought necessary to study the possible significance of age differences as a factor influencing the validity of the results inasmuch as the "normal" controls included a larger proportion of subjects in the lower decades (especially the third) than did the three groups of patients. Table 7 shows the incidence of abnormal laboratory findings arranged according to decades. This presentation shows that the incidence of abnormal tests exhibits only minor variations among the various age groups, indicating that age difference is not a significant factor affecting the incidence of abnormal findings in these subjects. The incidence of abnormal reaction to tests in the 36 patients in the third decade was 1.9 per subject as compared to 0.5 in the 13 normal controls of comparable age. The over-all incidence of abnormal reaction to tests in the 211 patients was 1.9 as compared to 0.4 in the 21 normal controls. In the individual groups of patients, the incidence was 1.9 for group 1, 1.9 for group 2, and 2.0 for group 3.

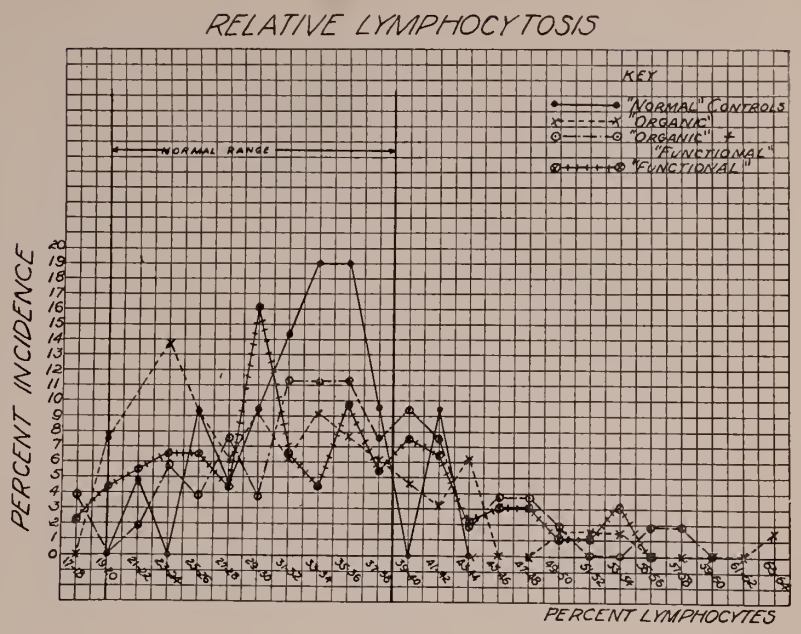


Figure 4

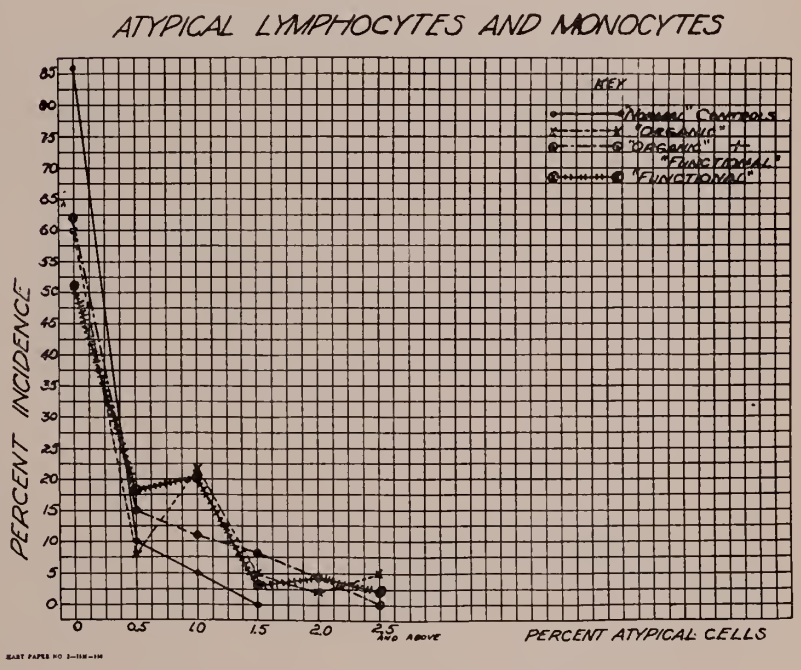


Figure 5

Consistency in Degree of Variation of Abnormal Findings As Shown by Distribution Curves for Each of Five Different Laboratory Criteria. Comparison of figures 2, 3, 4, 5 and 6 reveals a consistent trend towards similarity among the distribution patterns in the patient groups as opposed to the appearance of those of the normal controls. This lends additional weight to the significance of the purely numerical incidence of abnormal values among the subjects, which is summarized in figure 1.

Comments

Our study of an unselected group of office patients indicates that the great majority had objective evidence of physical disease. Abnormalities in a simple series of five laboratory tests were present just as frequently in patients with a clinical diagnosis of primary "functional" disease as in those with "organic" disease or a combination of the two. In "normal" volunteers who did not feel the need for medical aid and had never had serious illnesses of the type which tend to have chronic sequelae, the incidence of abnormalities was much less.

Although we have been able to demonstrate the relatively constant association of objective abnormalities with "functional" symptoms in our series, we realize that we have no direct data to help us determine which is cause and which is effect. It may be that the changes we have described are primarily due to emotional wear and tear. But it has been shown by others that some of the objective findings we have described are observed in subjects who have chronic symptoms simulating psychoneurosis following an acute attack of viral hepatitis[3] or infectious mononucleosis.[2] Such symptoms respond better to therapy directed primarily towards the underlying physical disease rather than to psychiatric manifestations such as physical rest, dietary measures, removal of foci of infection and administration of adrenal cortical extracts.[2-4] Under such circumstances, abnormal laboratory findings disappear as symptoms subside, even though the latter may have initially seemed emotional in origin. It therefore seems more likely that the objective findings we have described are the cause rather than the result of the nervous instability occurring in the patients with "functional" symptoms.

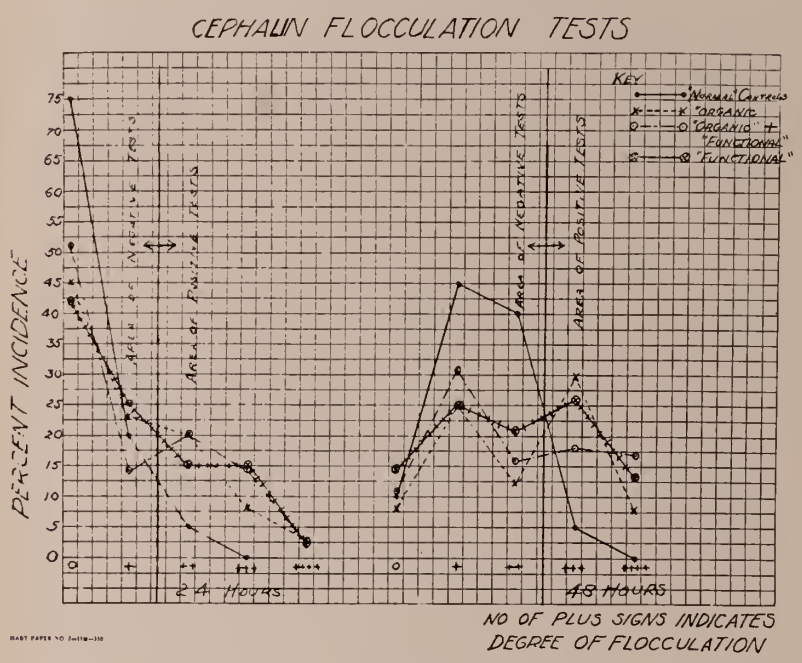


Figure 6

RELATIVE INCIDENCE OF ABNORMAL LABORATORY FINDINGS AMONG VARIOUS AGE GROUPS

Ages	Number of Subjects					Total Number of Positive Tests					Average Number of Positive Tests per Subject				
	"Organic"	"Organic" plus "Functional"	"Functional"	Total Patients	"Normal" Controls	"Organic"	"Organic" plus "Functional"	"Functional"	Total Patients	"Normal" Controls	"Organic"	"Organic" plus "Functional"	"Functional"	Total Patients	"Normal" Controls
10-19	4	1	1	6	1	12	2	1	15	1	3.0	2.0	1.0	2.5	1.0
20-29	9	9	17	35	13	17	22	28	67	6	1.9	2.4	1.6	1.9	0.5
30-39	7	9	36	52	2	9	24	69	102	0	1.3	2.7	1.9	2.0	0.0
40-49	7	10	21	38	4	14	18	43	75	1	2.0	1.8	2.0	2.0	0.3
50-59	18	17	12	47	0	33	27	30	90	0	1.8	1.6	2.5	1.9	—
60-69	17	5	5	27	0	36	6	11	53	0	2.1	1.2	2.2	2.0	—
70-79	2	2	1	5	1	0	4	3	7	0	0.0	2.0	3.0	1.4	0.0
80-89	1	0	0	1	0	1	0	0	1	0	1.0	—	—	1.0	—
Total	65	53	93	211	21	122	101	185	410	8	1.9	1.9	2.0	1.9	0.4

Table 7

Consistent with this conclusion is the finding of great similarity in incidence and distribution of abnormal laboratory findings among the three groups of patients, as contrasted to healthy subjects.

Our findings strongly suggest that any distinction between "organic" and "functional" disease is artificial. They show that similar physiologic-pathologic disturturbances can be detected in "organic" and "functional" disease by use of simple laboratory technics. These abnormalities may represent a common denominator which is the basis for the symptoms of instability occurring in patients with "functional" disease and may also be a prerequisite for the more obvious changes in tissue function and structure usually considered characteristic of "organic" disease.

Summary

Results are presented of the examination of 211 unselected patients in an internist's private practice as compared to 21 "normal" subjects. By routine use of the total white blood cell count, erythrocyte sedimentation rate, cephalin flocculation test and differential white blood cell count (with special care not to overlook atypical cells simulating

those seen in mononucleosis) it was shown that most patients had some objective evidence of abnormality, regardless of whether they had "organic" or "functional" disease by usual clinical criteria.

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ABSTRACTS OF MEDICAL ARTICLES

The Determination of the Blood Amylase in Fluid Aspirated from the Flank in Pancreatitis. By Frederick H. Bowen, M.D. South. M. J. 44:775-777 (Sept.) 1951.

A case of chronic relapsing pancreatitis, with autopsy, is reported, in which the patient eventually died of acute hemorrhagic pancreatitis. In this case, a blood amylase determination on fluid aspirated from the area of bluish discoloration in the flank was obtained and proved to be a helpful diagnostic procedure. On this aspirated fluid the blood amylase determination was 4,210 units, and the control value was 177 units.

The author observes that the appearance of an area of bluish discoloration in the flanks in a person who has had severe abdominal pain for a day or two is a well known but infrequent sign of hemorrhagic pancreatitis and is almost always pathognomonic of this condition. The bloody extravasation tends to extend retroperitoneally and gravitate downward and laterally, becoming apparent as a greenish yellow or purple area in the loins lateral to the erector spinae muscles.

A review of the literature indicated that a blood amylase determination on fluid aspirated from the flank in acute pancreatitis has not previously been reported. In certain cases of pancreatitis, this new diagnostic aid should be of value.

Prefrontal Lobotomy for the Relief of Intractable Pain. By James G. Lyerly, M.D. Am. J. Surg. 81:526-532 (May) 1951.

A series of 12 cases of intractable pain relieved by bilateral prefrontal lobotomy is reported. Included are 3 cases of painful amputation stump, 3 cases of carcinoma of the pelvic region, 2 cases of atypical facial neuralgia and 1 each of severe intercostal neuralgia, pain of head, neck and arm following cervical disk removal, and post-traumatic headaches and tinnitus. In every case the bilateral prefrontal lobotomy was performed because the unilateral operation too frequently has been ineffective in relieving patients with mental disorders. The operation does not abolish physical pain, but tends to change the mental attitude so that the patient does not suffer as he did before. In like manner, the mood is elevated, and there is a lessening of nervous tension, anxiety and fear of the future. It is an easy matter to withdraw opiates even though drug addiction was a major factor in the illness.

Dr. Lyerly concludes that prefrontal lobotomy should not replace cordotomy and other surgical measures for the relief of pain in all cases. He adds that the patient and the family should help in making the decision as to the procedure of choice.

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VOLUME XXXVIII
NUMBER 10

The Journal of the Florida Medical Association

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His Name Was Mudd

After John Wilkes Booth shot Abraham Lincoln at point blank range in the President's box at Ford's Theater in Washington, D. C., on the evening of April 14, 1865, he leaped from the box, caught a spur of one riding boot on the United States flag which draped the box and fell awkwardly to the stage ten feet below, fracturing the left tibia just above the ankle. Dashing as fast as he could through a rear entrance, the assassin kicked the chore boy who held a fast bay horse in readiness for him, mounted and rode across a bridge over a branch of the Potomac River into Southern Maryland.

Although Booth's plans had been laid carefully, he had of course not reckoned with an accident which would fracture his leg. As he rode south, he must have recalled that during the preceding November he had met Dr. Samuel A. Mudd near Bryantown, had ridden to his home located in Charles County about thirty miles south of Washington and had talked of buying his farm. Toward Dr. Mudd's home Booth now directed his horse. About 4 o'clock in the morning of the day following the assassination, Dr. Mudd admitted to his home a man who, so far as he knew, was a



stranger to him, for his features were disguised. With the stranger was a young man of boyish appearance who later proved to be David Herold. Both gave assumed names.

After the leg had been set and bandaged by the doctor, the stranger rested while his young accomplice went in search of a carriage. None being available, the two men decided to depart on horseback in the early afternoon during the doctor's absence. As they descended the stairs, Mrs. Mudd's suspicions were aroused when the crippled man's false whiskers became partially detached from his face. Upon the return of Dr. Mudd, his wife told him of her suspicions. The following day, from church in Bryantown, Dr. Mudd sent a message to the authorities telling of his experiences with the suspicious strangers. A few days later, he gave to an investigating officer the boot which he had cut off the patient's foot, inside of which was written "J. Wilkes ——." This boot furnished evidence which permitted the authorities to conclude one week after that tragic night that Booth was the assassin.

The violent death of Abraham Lincoln probably shocked the world as much as any previous single event in all history. At a time when better days seemed to be dawning for the nation as a whole, the assassination aroused throughout the land, North and South, an unparalleled excitement. Lincoln had become almost deified in the minds of Northern people, and many in the South were beginning to understand and respect him for his lofty virtues as a man.

Ralph Waldo Emerson said that the gloom of the calamity had traveled over sea and land from country to country "like the shadow of an uncalculated eclipse over the planet." Emerson doubted whether any one death had ever caused so much pain to mankind. Queen Victoria wrote a personal note to Mrs. Lincoln. Said Disraeli, England's Prime Minister, "There is in the character of the victim. . .something so homely and innocent. . . [that] touches the heart of nations. . . ." At first, General Robert E. Lee refused to hear the details of the assassination. The General said that he regretted the death of Mr. Lincoln as much as any man in the North and believed him to be the epitome of magnanimity and good faith.

Among those high in authority, however, some were at variance with the spirit of magnanimity and kindness of Lincoln; they developed a deep-seated conviction that victims must be offered for sacrifice. Dr. Mudd became one of these victims.

Born in Charles County, Maryland, on Dec. 20, 1833, Samuel A. Mudd became proficient in Greek, Latin and French and also in music, performing with skill on the violin, piano and flute. He was graduated from Georgetown College and then from the University of Maryland Medical School in 1856. After a one year internship, he began the practice of medicine on his father's large estate in Charles County. About a year and a half later, he married Miss Sarah Frances Dyer, whom he addressed later in many letters as "My darling Frank." He was a kindly country practitioner, who enjoyed nothing more than a peaceful hour with his family.

On April 26, Booth was shot and killed near Port Royal, Va., in a barn which had been set on fire and surrounded. Dr. Mudd and seven others were arrested and charged with complicity in the crime. At first Dr. Mudd did not take his arrest very seriously. Little did he realize that it would

Sketch of Fort Jefferson, Garden Key, Tortugas Islands, Florida, "The Key to the Gulf of Mexico," about the time Dr. Mudd was imprisoned there. Library of one of the Editors.



be four years before he would see his loved ones and home again.

President Andrew Johnson ordered on May 1 that the accused be tried by nine military officers. Many eminent attorneys throughout the country, including General Thomas Ewing who ably defended Dr. Mudd, contended that the civil courts alone had jurisdiction to try the accused.

The trial, which began on May 10 and ended on June 30, is thought by many to have been the worst blot on the American record of justice. Daniel Thomas, an outcast from his home who years later died in the penitentiary after being convicted of pension frauds, apparently gave false testimony against Dr. Mudd in the hope that he would receive part of the large reward offered for the capture and conviction of Booth and his alleged accomplices. Four of the accused were sentenced to be executed. One was sentenced to be confined at hard labor for six months. Dr. Mudd and two others were sentenced to be confined at hard labor for life.

On July 24, Dr. Mudd entered Fort Jefferson to begin his sentence. Construction of the fort had been started in 1846, on Garden Key in the Dry Tortugas group, some seventy miles west of the city of Key West. The structure was intended to complete a great link of forts from Maine to Texas. During construction the fort began to sink and crack, for the island was not solid rock. Although a shot was never fired from its cannon, the fort went down in history as one of the worst prisons and "death holes" anywhere in the world. First laborers, then soldiers and finally prisoners were victims of disease and hurricanes which swept the area.

In a letter addressed to his wife on August 24, Dr. Mudd stated that he was at that time serving in the hospital and had no labor to perform. His food consisted of coffee, bread and butter three times daily; occasionally Irish potatoes; molasses when he was able to buy it; fish when they could be caught.

In September, Dr. Mudd unfortunately attempted to escape and when captured was put at hard labor. Upon the arrival of every incoming ship, he was placed in the dungeon. On September 30, he wrote that at least three fourths of the inmates had suffered from "bone fever" (dengue). In October, he wrote that he was confined to a small damp room. In November, he told how the prisoners had been placed in leg irons without cause, marched to headquarters and put at hard labor cleaning old brick. In December, he stated: "We are still in irons. . . ." In January 1866:

> I have grown old in my youth. . . .Imagine one loaded down with heavy chains, locked up in a wet, damp room twelve hours out of every twenty-four on working days and all day on Sundays and holidays. . . . The atmosphere we breathe is highly impregnated with sulphuric hydrogen gas. . .generated by the numerous sinks that empty into that portion of the sea. . .which is immediately under a small port hole — the only admission for air and light we have from the external port. My legs and ankles are swollen and sore. . . .My hair began falling out sometime ago. . . .My eyesight is beginning to grow very bad, so much so that I can't read or write by candlelight. . . .My eyes are painful and irritated. . . .With all this imagine my gait with a bucket and broom, and a guard. . . .This has been our treatment for the last three months coupled with bad diet, bad water, and every inconvenience. . . ."

In July 1866, General Phil Sheridan intervened and secured better treatment for the prisoners. In August of that year, Dr. Mudd wrote that he was enjoying better health, which he attributed to the kindness of the officials in giving them a plank floor for their sleeping quarters.

On Aug. 18, 1867, a severe epidemic of yellow fever began at Fort Jefferson. When the post surgeon was stricken and was among the first to die, Dr. Mudd was placed in charge of the local hospital. One of his first acts was to abolish a hospital on distant Sand Key, to which "sick patients were conveyed seated in small boats facing coffins piled up in the bow." It is recorded that in many instances coffins were placed alongside the hospital beds there, in readiness to receive the body of patients expected to die, and "no sooner had the breath left the body, but that it was coffined and hurried over to its last resting place."

On September 8, Dr. Mudd wrote of the situation on Garden Key: "Nearly every man now on the island is infected with the disease. . . .The greatest consternation prevails. . . ." On September 13, he wrote: "Although three fourths of the garrison have been removed, the epidemic seems to increase with unabated fury. . . .I remain up every night until eleven or twelve, and sometimes later. . . ." The most remarkable spread occurred on the night of September 16 when thirty-five men composing one half of company M were stricken with the most malignant form of the disease between 11 and 2 o'clock.

On October 4, Dr. Mudd was stricken with the fever, but two weeks later he wrote that he had recovered. An unsigned petition was prepared by the garrison praising his work and requesting his release. After the epidemic subsided, however, he was again put in chains.

Finally, as a result of the unceasing efforts of

his wife and friends, Dr. Mudd was pardoned by President Johnson. He regained his freedom on March 8, 1869, after being imprisoned at Fort Jefferson for almost four years.

Although Dr. Mudd returned to Maryland and lived for nearly thirteen years, he apparently never again enjoyed robust health. While serving the sick at nighttime during a winter storm, he contracted pneumonia. Nine days later, on Jan. 10, 1883, he died. A martyr, not yet fifty years of age, Dr. Mudd was faithful to his patients and to his profession until the very end.



Dr. Samuel A. Mudd

From "The Life of Dr. Samuel A. Mudd" by Nettie Mudd, New York, The Neale Publishing Company, 1906. Jacksonville Public Library.

"Doctor, What Plans Have You Made?"

Are you looking ahead, Doctor? Have you given careful thought to intelligent financial plans for the future? "But physicians are, perhaps, the poorest examples of constructive planning." So wrote John Alan Appleman, J.D., in a thought-provoking article entitled "Even Physicians Die," which was published in the December 15 issue of the Journal of the American Medical Association. Every member of the medical profession would do well to peruse it with care.

The picture portrayed of young Dr. Jones as he climbs the ladder of success may cause the reader discomfort, but only so because it strikes too close to home. The author finds it "typical of the majority of physicians — some of whom survive to experience a few of these headaches, others of whom leave these problems to widows and heirs."

Dr. Appleman makes clear the physician's need for estate analysis — a specialty combining elements of taxation, will review, trusts, investments, insurance, and many other phases of law and business, which has come into being because of acute taxation and personal problems such as confronted Dr. Jones. Basically, it is "a philosophy — a philosophy both for living and for death which works to solidify the relationships existing between a man and his family and to provide for the family's comfort after his death, but without destroying them as persons." It is as much concerned, however, with the art of successful living as it is with plans for death.

Physicians who missed this article will profit by digging out the Dec. 15, 1951 A.M.A. Journal and reading it, as did one Journal reader who thoughtfully directed the attention of the Editors to it.

American Medical Education Foundation

April 1 marks the beginning of the 1952 drive of the American Medical Education Foundation for funds to continue the work of supporting medical education. "Though much was done in '51 — there's more to do in '52," said Dr. Elmer L. Henderson, Louisville, Ky., President of the Foundation, as he sounded the call to action for the second year's drive at a conference in Chicago in mid-February. Physician leaders in medical philanthropy from forty-eight states attended this meeting, held for the purpose of stimulating action by the individual states for the current drive being conducted during April, May and June. Dr. Jack Q. Cleveland of Coral Gables ably represented the Florida Medical Association at the conference.

In a special message in the February 1952 issue of The Journal, President David R. Murphey, Jr., set forth tersely the need for and the background of this movement which has already gained great

momentum as it enters its second year. Hardly a member of the medical profession is unaware of the precarious financial condition of this country's medical schools today. Most physicians also realize that the American Medical Association forthrightly led a movement to remedy their plight by organizing the American Medical Education Foundation and contributed half a million dollars to serve as a nucleus for last year's fund. It has made a gift this year in like amount, bringing to a total of one million dollars its contributions to the Foundation since its inception little more than a year ago. It also underwrites all of the Foundation's expenses so that every dollar of every contribution received goes in full to the medical schools.

An important change in policy this year makes it possible for alumni and friends of a specific medical school to contribute to that school through the Foundation and the school will receive the full amount of the contribution plus its full share of unearmarked funds.

The first year's experience has demonstrated that the success of the foundation is to be measured in terms of action at the state and county level. The number of contributions already received in 1952, prior to the opening of the campaign, reflects the growing interest largely stimulated by the increasingly active efforts of state and county societies. The Florida Medical Association will undoubtedly wish to have a generous share in this nationwide project.

Many physicians are recognizing for the first time the debt they owe their medical schools, while many others see in the activities of the Foundation a channel through which the medical profession has an excellent opportunity to demonstrate its willingness to aid in the advancement of high standards of medical education. The success of the present effort will constitute a real challenge to business, industry, agriculture and other important groups concerned with medical education to contribute generously to the solution of this problem. The source from which financial support is obtained will inevitably determine whether the medical schools are to continue to function as integral and independent institutions or whether they are to become subject to federal supervision and subsequent control.

Apathy in Voting

"Socialism can easily come to this country without a vote of the people. It can come by default." This warning in the Dallas Morning News not long ago was provoked by information carried in Dallas, Texas, newspapers on the response of the voting public in that city. With only 26 per cent of the members of the seven leading Dallas professional groups voting in the last Presidential election, the heaviest vote was in the legal profession with a mere 38 per cent of the lawyers casting their ballot. The medical profession was a close second to the lawyers with 36 per cent of the physicians voting. The nursing profession made the poorest showing with only 12 per cent.

In the light of such figures it is understandable that the Dallas Morning News should envision socialism by default and comment further:

"It is the doctor, the lawyer, the engineer who bemoan the threat of socialism and burdensome debts. The doctor who fears socialized medicine and does nothing at the polls to combat it is legion. The Dallas poll merely proves locally a national picture that is pitiable.

"The result is a government of pressure groups alert to step in where others fail to tread.

"Polls similar to that in Dallas show 85 per cent of labor union membership votes. The figure is 90 for those who hold government jobs. Not only do they vote, they influence others. This is their civic privilege; we might even say duty, though it is a duty with a motive."

Remarking editorially upon the apathy of citizens of this country regarding voting, the Los Angeles Mirror recently estimated that less than 50 per cent of qualified United States voters exercise their privilege of voting in national elections. The voting rate in Los Angeles is between 20 and 35 per cent, a dismal showing indeed when compared to Great Britain, where national elections are said to bring to the polls 85 per cent of the voters.

Every physician should read the editorial, "Voting Privileges," which appeared in the Dec. 29, 1951 issue of the Journal of the American Medical Association. In showing up the apathy of the citizens when the elections roll around, it summarized the aforementioned newspaper information and expressed the belief that professional groups, especially physicians, now show a much greater interest in voting. "It certainly can be said without fear of contradiction that in the country at

large there has been sharply increased interest in registering and voting on the part of the medical profession. However, there is still room for improvement, and all physicians, as well as other members of professional groups, and especially those concerned with health, should recognize their obligations as citizens in these critical times."

Surely, as suggested, the professional groups should begin now without further delay to shoulder their responsibilities as voters and citizens and to take full advantage of the peculiar opportunity which is theirs for leadership in civic activities. The "year of decision" is at hand, and there is no time to lose. Waiting till the last minute may be too late to better the 1948 record.

New Tests in the Etiologic Diagnosis of Diabetes Mellitus

Is the "Higher Cost of Medical Care" Justified?

The technologic advances of the past two decades have introduced radically new factors in the practice of medicine. These new factors have so increased the complexity in the field of medical diagnosis and in the interpretation of the mechanisms of disease that the amount of knowledge and time for study and the cost of the equipment required of the average physician today can no longer be compared with those required of the practitioner of the first quarter of this century.

Each new technologic discovery has opened a vast new field of research. Each new research activity has added to the complexity of medical science and, as a natural corollary, to the economic burden of an up-to-date type of medical practice. The stethoscope, the microscope, the x-ray machine, the electrocardiograph, the spectrophotometer, are but a few of the innumerable milestones on the road to progress in the care of the sick and in the prevention of disease. Each one of them, of course, has added an ever increasingly expensive item to the bill we must pay for medical care.

Are these ever growing costs worth while to us as members of the human race? How do they reflect upon our everyday living as individuals, and as a nation?

One answer is given in the Statistical Bulletin of the Metropolitan Life Insurance Company for January 1952.[1] The industrial policyholders of this company, who constitute a large cross section of wage earners and their families in the United States and Canada, have shown such an improvement in their health that the average length of life in this group has increased by five years in the past decade and by ten years since the early 1930's, even with the the inclusion of war deaths in the computations. "Under the mortality conditions of 1911, the expectation of life at birth in this insured group was 46.6 years, or 6½ years less than for the general population of the U.S." In 1951 this life expectancy has reached the new high of 68.5 years, an extension of 21.9 years during the last four decades. "The very favorable health conditions which now prevail reflect the cumulative effect of marked advances in all branches of medical science and practice, the growth and the more efficient use of medical and public health facilities and the economic prosperity of recent years," which have made such advances and their application possible.

As an illustration of the influence of these costlier but so useful technologic improvements, we find that "Diabetes, one of the major degenerative diseases, registered a decline of five per cent in the crude death rate from 1950 to 1951."

Mortality rates in diabetes have been declining for thirty years, since the discovery and application of insulin has permitted better understanding and management of the disease. But science is never satisfied at any level of progress. Further improvements are constantly sought. Research continues, stimulated by newer discoveries in related fields of science. Now we are able further to clear up the fog of ignorance, and as we become better acquainted with the intimate mechanisms of carbohydrate metabolism, we may expect an even greater degree of diabetes control. The results are already showing in a rapidly expanding life expectancy and a better life for the diabetic patient.

In the past decade it has been emphasized that normal carbohydrate tolerance depends in many instances not on the functional integrity of the pancreas but rather on a normally functioning liver and on maintenance of the balance between the action of insulin and the hormones of the anterior lobe of the pituitary and the adrenal cortex. Translated into simple facts, these observations mean that we know diabetes mellitus is a syndrome which may be produced by a variety of pathogenic mechanisms. The pancreas, which for many years was considered the seat of the primary disturbance, may even remain entirely normal, both in the organic and the functional senses.

A purely hepatic diabetes, nonendocrine and due primarily to disease of the liver, can now be demonstrated. Endocrine types of diabetes may

be produced by disturbances of either the pancreas or the pituitary-adrenal axis.

As a result of pituitary-adrenocortical stimulation with an increase in circulating ll-oxysteroids, the administration of glucose in the normal person is followed immediately by a fall in the absolute lymphocyte count. This phenomenon occurs only in about one half of all diabetic patients, indicating a normally functioning pituitary-adrenal axis. The other half probably suffers some disturbance of this axis, so that the lymphocyte response to administered glucose may be employed to distinguish a diabetes associated with dysfunction of the pituitary-adrenal axis from one due to other factors.

There is also a decrease in serum inorganic phosphorus in the normal person after glucose administration. This phenomenon is not seen in a large percentage of diabetic patients. Since experimentally the response of serum inorganic phosphorus level occurs in the absence of the liver but not in the pancreatectomized animal, this reaction is believed to be significant of peripheral glucose utilization and has been suggested by Forsham and Thorn to distinguish diabetes associated with normal peripheral glucose utilization (intact pancreas), assumed to be due to hepatic dysfunction, from diabetes associated with deficient peripheral glucose utilization, considered to be due to either relative (pituitary-adrenal) or absolute (pancreatic) insulin lack.

In a recent study by Lazarus and his co-workers,[2] the simultaneous study of the response of lymphocyte counts and phosphorus levels to administration of glucose in 17 unclassified cases of known diabetes helped to separate them into 9 cases in which the etiology was probably pituitary-adrenal dysfunction, 6 in which diabetes was due to hepatic dysfunction and only 2 in which the disease was actually due to pancreatic insufficiency.

These findings will not necessarily reflect immediately upon our present methods of treatment for the diabetic patient. The time-proved adequate diet, insulin and exercise are still the basis of correct management of the disease. But who can deny that, as we begin to differentiate the disease into more accurate etiologic classifications, our methods of control will improve? In view of these recent technologic improvements, it would not be too adventurous to predict the possibility of an eventual permanent cure for at least certain types of diabetes.

These considerations seem to justify fully the expense of new diagnostic technics. We must accept the fact that in the present advanced status of our scientific knowledge, a "two dollar diagnosis" no longer will always satisfy completely the needs of our enlightened population.

But these facts must be explained to the lay public if we are to dispel the common criticisms against the high cost of medical care. John Q. Citizen must realize that what he pays for today is better health and extra years of life to enjoy it. No expense can then be considered too high.

1. Excellent Health Record in 1951, Statist. Bull. Metrop. Life Insur. Co. 33:1-7 (Jan.) 1952.
2. Lazarus, S. S.; Volk, B. W.; Jacobi, M., and Gilady, Miriam Y.: Absolute Lymphocyte Count and Serum in Organic Phosphorus after Glucose Administration in Diabetic Patients, Am. J. Clin. Path. 22:127-134 (Feb.) 1952.

Graduate Medical Education

This is the twentieth year the Florida Medical Association and the University of Florida have sponsored graduate medical education for the physicians of Florida. The major feature annually is the Graduate Short Course, which will be presented this year the week of June 23. For approximately ten years the Committee on Medical Postgraduate Course has planned highly specialized courses either the first two days of the Short Course or just prior to the Short Course. Because many wish to attend both the specialized courses and the Short Course, it was decided the special courses should be given the week before the Short Course.

Seminar on Diagnosis

On June 19-21 a Seminar on Diagnosis is being offered at the George Washington Hotel in Jacksonville. The program is a most excellent one, and the specialists, Drs. Lewis M. Hurxthal, Hugh F. Hare and William A. Meissner of the Lahey Clinic, Boston, are all outstanding medical teachers. We are most fortunate to have come to us three such men who are associated in their daily work and who can correlate their lectures. While the program is primarily designed for internists and general practitioners, nevertheless because diagnosis

NOTICE

Your March Journal carried a complete program and other detailed information relative to the Seventy-Eighth Annual Meeting of the Association in Hollywood, April 27-30.

is pertinent to all physicians practicing medicine, we believe any physician would profit by attending. The program follows:

Thursday, 9:30 a.m.

Symposium on Thyroid Disease

Normal Thyroid Function
Simple and Nodular Goiters
(Intermission, 30 minutes)
Intrathoracic Goiter
Thyroid Tumors, Pathology, Diagnosis and Treatment

Thursday, 2 p.m.

Symposium on Thyroid Disease

Physiology and Pathology of Hypofunction
Pituitary Relationships
(Intermission, 15 minutes)
Cretinism, Myxedema
Physiology and Pathology of Hyperfunction, Adenoma, Adenomatous and Hyperplastic Goiter
(Intermission, 15 minutes)
Diagnosis and Treatment

Friday, 9 a.m.

Adrenal Diseases—Dr. Hurxthal, Dr. Meissner

Physiology, Etiology, Diagnosis, Pathology and Treatment (90 minutes)
(Intermission, 15 minutes)

Lymph Node Disease—Dr. Hare, Dr. Meissner, Dr. Hurxthal

Clinical Manifestations, Diagnosis, Pathology and Treatment

Friday, 2 p.m.

Lung Tumors—Dr. Hare, Dr. Meissner

Clinical Manifestations, Diagnosis, Pathology and Treatment (90 minutes)
(Intermission, 15 minutes)

Metabolic Bone Disease—Dr. Hurxthal, Dr. Hare, Dr. Meissner

Clinical Manifestations, Diagnosis, Roentgen and Pathologic Recognition, and Treatment (90 minutes)

Saturday, 9 a.m.

Clinicopathologic Conference, with Discussion of Clinical and Laboratory Methods of Diagnosis

Demonstration (2 cases) — Dr. Hurxthal, Dr. Hare, Dr. Meissner (120 minutes)

Medical Licenses Granted

Dr. Homer L. Pearson, Jr., Secretary of the State Board of Medical Examiners, has reported that of the 190 applicants who took the examination of the Board, held November 26 and 27, 1951 in Jacksonville, 161 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 161 successful applicants follow:

Abrahamson, Ira Adolph, Jr., Cincinnati, Ohio (U. of Cincinnati 1948)
Adams, Leslie Rudolph, Jacksonville (U. of Pennsylvania 1951)
Akes, Charles Delbert, Tampa (U. of Illinois 1951)
Altman, Donald H., Miami (U. of Tennessee 1950)
Anderson, Raymond Thomas, Detroit, Mich. (Wayne U. 1942)
Anlage, Henry Joseph, Miami (St. Louis U. 1950)

Baker, Hillier Locke, Chicago, Ill. (Rush Med. Coll. 1915)
Barland, Samuel, Elmhurst, N. Y. (Maryland Med. Coll. 1929)
Beidleman, Barkley, Pensacola (Harvard U. 1944)
Belyeu, Jesse Harvey, Jacksonville (Tulane U. 1951)
Bidgood, Willis Deanes, Birmingham, Ala. (U. of Pennsylvania 1946)
Blackford, Florence, Miami (Indiana U. 1934)
Blatt, Lester Jay, Coral Gables (New York U. 1943)
Brandon, James Robert, Greenville, S. C. (Med. Coll. of Virginia 1942)
Braunstein, John Rutley, Cincinnati, Ohio (U. of Cincinnati 1943)
Buerk, Minerva Smith, Evanston, Ill. (Woman's Med. Coll. of Pennsylvania 1946)
Bumgardner, Heath Denton, Philadelphia, Pa. (Temple U. 1942)
Burgh, Lois Cleone, Tallahassee, (Scotland, 1942)
Burke, Sean Kevin, St. Petersburg (Harvard U. 1951)

Campbell, Francis Joseph, Opa Locka (Coll. of P. & S., Boston, 1938)
Capidaglis, Andre Stephan, Miami (Cornell U. 1946)
Carleton, Charles Coleman, Orlando (McGill U. 1950)
Carpenter, Frederick Albertin, Chamblee, Ga. (Emory U. 1951)
Castleberry, Jesse Wendell, Birmingham, Ala. (Northwestern U. 1950)
Cecil, Russell LaFayette, New York, N. Y. (Med. Coll. of Virginia 1906)
Clark, Edward John, Jacksonville (Jefferson 1950)
Coggan, George Michael, Birmingham, Ala. (Med. Coll. of Alabama 1951)
Cole, J. P., Alma, Ark. (Columbia U. 1944)
Conn, James Keener, Staten Island, N. Y. (Washington U. 1948)
Crage, Francis Michael, Chicago, Ill. (U. of Buffalo 1919)
Crago, John Alfred, Rochester, N. Y. (Cornell U. 1950)
Culpepper, Walter Shelley, New Orleans, La. (Tulane U. 1940)

Davis, Courtland Harwell, Jr., Durham, N. C. (U. of Virginia 1944)
Davis, Robert Jay, Lake City (Johns Hopkins U. 1940)
Dayton, Helen Conger, Miami (U. of Tennessee 1951)
Deam, John Henry, Tampa (Jefferson 1951)
Dean, George Walter, Milwaukee, Wis. (U. of Wisconsin 1934)
DeNote, Anthony Paul, Philadelphia, Pa. (Jefferson 1936)
Denser, Clarence Hugh, Chattahoochee (U. of Cincinnati 1917)
Deurloo, Henry William, Gainesville (U. of Michigan 1936)
Duest, Lloyd Joseph, New Bedford, Mass. (Tufts Coll. Med. Sch. 1937)

Eisenbarth, Elmer John, Miami (Indiana U. 1951)
Ettinger, Charles David, Daytona Beach (New York U. 1950)
Eversole, Joseph Wilson, Jacksonville (U. of Virginia 1940)

Feigelson, Howard Harvey, Miami (U. of Cincinnati 1950)
Feigenbaum, David, Miami Beach (Tulane U. 1951)
Flynn, Joseph Charles, Orlando (Jefferson 1951)
Folmer, Edward Joseph, New York, N. Y. (Georgetown U. 1941)
Foster, Richard Leland, Ft. Lauderdale (U. of Louisville 1943)
Freedland, Marvin Sol, Miami (Chicago Med. Sch. 1951)
Fromang, Vernon Leroy, Daytona Beach (Emory U. 1950)

Gaines, Gartrell Jerome, Jr., (Col.), West Palm Beach (Howard U. 1950)
Galluccio, Anthony Carmelon, Ft. Lauderdale (New York U. & Bellvue Med. Coll. 1927)
German, Walter Abel, Jr., Miami (Washington U. 1951)
Gerson, Theodore Frederick, West Palm Beach (Temple U. 1945)
Gillespie, Russell Hardy Dean, Neptune Beach (U. of Michigan 1951)
Gillikin, Charles Monroe, Mobile, Ala. (Bowman Gray Sch. of Med. 1946)
Gillman, Aron Nathan, Coral Gables (U. of Georgia 1945)
Gittelson, George, Miami (U. of Pennsylvania 1951)
Glucroft, Stephen Henry, Jacksonville (Long Island Coll. of Med. 1947)
Goldberger, Emanuel, New York, N. Y. (Long Island Coll. of Med. 1936)
Goodman, Julian John, Ft. Bragg, N. C. (U. of Vermont 1948)
Gouchnour, Thomas Henry, Jacksonville (Indiana U. 1951)
Greenhouse, Jerome Mayer, St. Louis, Mo. (St. Louis U. 1939)
Grosz, Eugene, Evanston, Ill. (Czechoslovakia 1920)
Gunion, Frederick Ashley, Coral Gables (Med. Coll. of Virginia 1951)
Gunsolus, John Martin, Miami (U. of Minnesota 1951)

Hall, Fairfax, New Rochelle, N. Y. (Columbia U. 1911)
Harris, James Allen, Cincinnati, Ohio (Duke U. 1950)
Head, Thomas Duncan, Gainesville (Med. Coll. of Alabama 1950)
Healey, Raymond Walter, Miami (St. Louis U. 1951)
Hobson, John Lewis, Jacksonville (Vanderbilt U. 1949)
Horwitz, Michael Lee, Miami Beach (Chicago Med. Sch. 1951)

Kellerman, Edgar Allen Poe, New York, N. Y. (New York U. 1939)
Kelso, Kip Gordon, Tampa (U. of Oklahoma 1946)
Kobak, Mathew William, Chicago, Ill. (U. of Chicago 1941)
Kulvin, Max Mandel, Miami (Rush Med. Coll. 1916)
Kummer, William Martin, New Orleans, La. (Hahnemann Med. Coll. of Phila. 1941)

LaRoche, Laurent Pierrepont, Orlando (Med. Coll. State of S. C. 1951)
Lawrence, Ralph Lewis, Tallahassee (Med. Coll. State of S. C. 1921)
Leininger, Hilbert Adolph Peter, Miami (Indiana U. 1939)
Levatin, Bernard, Coral Gables (U. of Illinois 1946)
Litt, Edward Theodore, Miami Beach (U. of Pennsylvania 1924)
Lockwood, Raymond Max, Clearwater (U. of Pittsburgh 1943)
Long, Frank Groover, Jacksonville (Temple U. 1951)

Macdonald, Ian John, Orlando (Tufts Coll. Med. Sch. 1951)
Mahoney, Paul Leo Jr., Jacksonville (U. of Arkansas 1951)
Mahrer, Martin Paul, Youngstown, Ohio (Hungary 1915)
McCallen, Albert Merle, Miami (Northwestern U. 1937)
McIntyre, Clifford Edward Locke, South Miami (Columbia U. 1944)
Meadows, Burton Thomas, St. Petersburg (New York U. 1943)
Mein, Robert Malhert, Jacksonville (U. of Louisville 1939)
Meli, John James, Columbus, Ohio (U. of Maryland 1951)
Mendelson, Joel, Panama City (Emory U. 1950)
Menge, Louis, New York, N. Y. (Coll. P. & S., Kansas City 1943)
Mikes, Frank Leo, Shaker Hgts., Ohio (St. Louis U. 1940)
Mitchell, Andrew Chrismond, Tampa (U. of Virginia 1951)
Moncure, William Bigbie, Richmond, Va. (Med. Coll. of Virginia 1949)
Morse, Irwin S., Coral Gables (Chicago Med. Sch. 1950)
Mullen, Sanford Allen, Virginia Beach, Va. (Columbia U. 1949)
Murray, Charles Alvin, Bay Pines (Northwestern U. 1936)

Nash, Norman, Miami (New York Med. Coll. 1948)
Neil, Robert Lewis, Memphis, Tenn. (U. of Tennessee 1951)

O'Brien, Paul Stevens, Miami (Ohio State U. 1951)
Owen, Richard Deen, Tampa (Jefferson 1951)

Parks, Raymond Edward, Miami (Yale U. 1945)
Patras, Mary Cornelia, Miami (Loyola U. 1935)
Patton, William Thomas, New Orleans, La. (Tulane U. 1946)
Pauley, Harvey Chadwick, Jr., St. Petersburg (Tufts Coll. Med. Sch. 1944)
Perdue, Maxine Roberta, Miami (Duke U. 1943)
Perry, John Fleck, Orlando (U. of Buffalo 1951)
Pinkus, Walter Howard, Tampa (U. of Illinois 1947)

Reiger, Anthony C., Miami Beach (Long Island Coll. of Med. 1931)
Robinson, Murry Myer, Washington, D. C. (George Washington U. 1935)
Robertson, James Farish, New Smyrna Beach (U. of Pennsylvania 1913)
Roddy, Stephen Robert, Miami (U. of Tennessee 1951)
Rosof, Jacob Agassiz, Hollywood (U. & Bellevue Med. Coll. 1931)

Schmidt, Ivan Clair, Lantana (Ohio State U. 1943)
Schmitt, Norman Lawrence, Detroit, Mich. (Wayne U. 1936)
Schwarz, Marvin Jerome, Miami Beach (Wayne U. 1950)
Senese, John Gerard, Brooklyn, N. Y. (Long Island Coll. of Med. 1914)
Shackleton, John Henry, Jr., Jacksonville (Jefferson 1943)
Sherman, John James, Huntington, W. Va. (Rush Med. Coll. 1941)
Shupe, Henry Wren, Jacksonville (U. of Oklahoma 1949)
Silberman, Harold Myron, Miami (Johns Hopkins U. 1951)
Sims, Murry, Coral Gables (U. of Michigan 1945)
Skyer, Roslyn, West Palm Beach (Hahnemann Med. Coll. of Phila. 1946)
Skyer, Joseph Robert, West Palm Beach (Hahnemann Med. Coll. of Phila. 1943)
Small, George Allen, Brookline, Mass. (Tufts Coll. Med. Sch. 1936)
Small, Sidney Robert, Los Angeles, Calif. (U. of Illinois 1943)
Smith, Freddie Alphonso (Col.), Tampa (Meharry 1950)
Startzman, John Edward, Orlando (Ohio State U. 1946)
Suarez, George Joseph, Tampa (U. of Havana 1946)
Summers, William Boyd, Miami Beach (U. of Colorado 1951)

Talley, Robert Gene, Miami (U. of Tennessee 1950)
Talley, William Richard, Lake City (U. of Louisville 1942)
Tanner, Charles Louis, Miami (Johns Hopkins U. 1951)
Taylor, Willard Mitchell, Ft. Lauderdale (Indiana U. 1940)
Tierney, Kaden, Hyattsville, Md. (George Washington U. 1942)
Tinkler, William Phillips, Miami (Vanderbilt U. 1951)
Tippett, Samuel Nelson, Miami (Ohio State U. 1951)
Tomlinson, Wray Joseph, Jacksonville (Temple U. 1935)
Turek, Samuel Lester, Chicago, Ill. (Northwestern U. 1935)

Updike, Edwin Hoyt, II, Jacksonville (Columbia U. 1949)

Vihlen, Frederick Englebirth, Miami (Temple U. 1951)

Wainer, William Wolfe, Providence, Ky. (Boston U. 1936)
Walker, Ambrose Taylor, Jr., Mammoth Spring, Ark. (U. of Arkansas 1946)
Walker, Francis Samuel, Orlando (St. Louis U. 1951)
Walker, Nancy Adine, Valparaiso (Louisiana State U. 1949)
Wallace, William Earle, Orlando (Jefferson 1951)
Warrington, James Clyde, Coral Gables (Coll. of P. & S., Boston 1942)
Weir, Hughey Monroe, Jacksonville (Med. Coll. of Alabama 1951)
Wells, Carl Hunt, Jacksonville (George Washington U. 1941)
Wells, Leila Hulbert, Jacksonville (George Washington U. 1941)
White, Charles Maxwell, Miami (U. of Pennsylvania 1951)
Wilber, Stewart Anthony, Jacksonville (Albany Med. Coll. 1946)
Williams, Gerald Stephen, Weirsdale (Tulane U. 1944)
Wilson, Joseph Crawford, Hollandale, Miss. (Tulane U. 1939)
Winslow, Oliver Parry, Jr., Coral Gables (U. of Maryland 1945)
Woodhall, Jerry Philip, Macon, Ga. (Johns Hopkins U. 1941)

Zimmerman, Daniel Harold, Miami Beach (U. of Baffalo 1951)

Procedure for Establishing and Maintaining Cancer Clinics Adopted by Florida Cancer Council, Tampa, Florida, January 18, 1952

Lorenzo L. Parks, M.D., Secretary
Jacksonville

A Cancer Clinic should be located in a general hospital which is approved by the American College of Surgeons.

A general hospital qualified to operate a Cancer Clinic must have the following key staff members available to serve the Cancer Clinic: (1) Pathologist, (2) Radiologist, (3) General Surgeon, (4) Gynecologist, and (5) Internist.

The following specialists should be available from the hospital staff as consultants: (1) Otorhinolaryngologist, (2) Orthopedist, (3) Urologist, (4) Thoracic Surgeon, and (5) Dermatologist.

It is advisable that a standing committee, known as the Cancer Committee or Tumor Board, etc., be appointed by the staff of the hospital. This committee will have the responsibility of the cancer program in the hospital inclusive of the Cancer Clinic.

One of the physician staff members must be designated as the director of the clinic.

It is essential that the services of a secretary be available to the Cancer Clinic, preferably full time. In addition, a nurse or combination nurse-social worker should be assigned to the Cancer Clinic.

The Cancer Committee should formulate the operational plan for the Cancer Clinic and have it approved by the medical staff and governing board. This plan should define in detail such items as the purpose, organization, personnel, conferences, source and disposition of patients, relationship to other organizations, and other pertinent information concerning the operation of the Cancer Clinic. Once approved by the hospital medical staff, it should be published for the guidance of all concerned.

It is advisable that the above operational plan for the Cancer Clinic, already approved by the hospital staff, then be submitted to the County Medical Society for its approval.

If financial aid is desired in the establishment and operation of the proposed Cancer Clinic, it is necessary that the Clinic plans also be submitted for approval to the Florida Cancer Council after approval by the local County Medical Society. Such financial aid is obtainable for certain phases of clinic operation, etc., from the Florida State Board of Health and from the Florida Division of the American Cancer Society as follows:

Under the present arrangement the Florida State Board of Health may assist in the salaries of personnel or in providing equipment.

The Florida Division of the American Cancer Society may assist in salaries of personnel and may provide funds for supplies and expendable equipment.

Following the American College of Surgeons' Standards, Cancer Clinics may be classified as follows: (1) Cancer Clinics offering full diagnostic and therapeutic facilities, (2) Diagnostic Cancer Clinics, and (3) Hospital departments conducting acceptable cancer programs.

Meeting and Procedure

Each clinic shall have regularly scheduled periodic meetings and shall have a minimum attendance of 80 per cent of the regular members. Consultative members shall maintain 80 per cent attendance when notified of presentation of cases in their specialties.

After diagnosis has been established and recommendations made, those patients without a family physician, and those not eligible for state aid, shall be directed to a panel of approved physicians. Voluntary patients with a family physician, and patients referred to the clinic by private physicians, shall be returned to the physicians concerned with the diagnosis and recommendations of the tumor clinic staff.

Clinics must keep clinical records, cross indices and follow-up files on each case, and these files

should be in accordance with the standards set up by the American College of Surgeons.

All data compiled and recorded by clinics should be made available to authorized representatives of the American College of Surgeons or other supporting agencies if occasion arises.

Cases should be presented at clinic meetings before any therapy has been instituted when feasible.

All cases of tissue diagnosis of tumors presented at approved Cancer Clinics should be submitted with pertinent data to the central tumor registry of the State Board of Health.

The diagnostic nomenclature used by the registry should be in conformity with that recommended by the American College of Surgeons.

General Plan of Operation

Under ideal circumstances, all new tumor cases should come before the staff on first admission to the clinic (either as in-patient or out-patient). However, in large institutions this would tend to overburden the staff with non-problematical cases, and in all institutions might be productive of delay. Hence, a working plan for the average institution might be as follows:

Cases in which surgery is the accepted mode of treatment and which are in prompt need of such (e.g. annular tumor of descending colon) do not need routine presentation in persons. A filled out "approved case record" will be sufficient.

Cases in which radio therapy is the accepted mode of treatment (e.g. small cutaneous angiomata) could be handled similarly. The correctly filled out case record form would be furnished for notification purposes.

Cases in which operation or irridation *might* be but are not unquestionably indicated (either alone or in combination), (e.g. a Stage II carcinoma of the breast) should be shown.

All problem cases in which the procedure is not clear cut should be presented at conference.

The actual therapeutic results, immediate and remote, should be carefully analyzed at regular intervals.

Case records forms should be those as already adopted by the American College of Surgeons or those records showing diagrammatic sketch picturing the lesion and its location. These complete cancer records should be kept available by the tumor clinic secretary.

Follow-up: In order to properly evaluate a cancer program cases should be followed up for a period of at least five years. Many well organized clinics are able to follow up 90 per cent of their cases for this period or longer.

Diagnostic Clinics

The cancer diagnostic clinic is a cancer clinic adapted to the needs of communities and hospitals where the case load is not sufficient to justify full therapeutic equipment or where such equipment is not available. Organization, personnel, conferences, records, and methods of handling patients should be planned as nearly as possible along the same lines as outlined for fully equipped clinics. The cancer clinic staff meets at stated times, acts in a consultative and diagnostic capacity and makes recommendations for treatment. For such a group, close affiliation with some nearby treatment center, to which patients requiring radiation therapy or special surgical procedures will be customarily sent, is desirable. After such treatments these patients can be followed up in the local clinic and an interchange of reports on the therapy used and the notes of the subsequent follow-up will complete the records of both clinics.

In smaller hospitals employing part time pathologists and radiologists arrangements usually can be made to hold the clinic at a time when both men are at the hospital. In a small community the appointment of a permanent staff to the clinic is fully as important as in a large hospital.

YOUR BLUE SHIELD

Blue Shield Annual Meeting

The annual meeting of Active Members of Blue Shield of Florida, Inc., will be held on Sunday, April 27, 1952, at 10:00 a.m. in the northeast dining room at the Hollywood Beach Hotel, Hollywood, in conjunction with the annual convention of the Florida Medical Association. This is an excellent opportunity for Blue Shield physicians to learn first-hand the problems and activities of their plan, and to have a voice in the affairs of the corporation.

Election of Directors

According to the By-Laws of the Plan, the Board of Directors is made up of eighteen directors, chosen as follows: Two participating doctors from each medical district of the Florida Medical Association; two or more participating doctors from the Florida Medical Association's membership at large, and one or more laymen from each medical district

of the Florida Medical Association. All directors are elected by the Active Members of the Corporation and serve for a period of three years each. At the first meeting of the Corporation directors were elected to serve for terms of one, two and three years in order that an equal number of terms would expire each year thereafter.

The following vacancies must be filled this year from the respective medical districts: "A"— one doctor, "B"— one doctor and one layman, "C"— one doctor and one layman, and "D" — one doctor and one layman.

It is not too late for participating physicians who are not now Active Members to make application to the Plan to serve in this capacity, and thereby become eligible to attend the annual meeting. Active membership requires that no dues be paid and does not obligate the physician in any way.

STATE BOARD OF HEALTH

Psittacosis

Psittacosis is primarily an avian infection, but occurs sporadically and in epidemics among the human population. The etiologic agent in birds and man is an obligatory intracellular parasite which belongs to a group of viruses including the infective agents of lymphopathia venereum, meningopneumonitis, and murine and feline pneumonitis. The host range of psittacine virus includes psittacine birds, canaries, pigeons, sea gulls, chickens, ducks, and other fowl.

The avian virus may be transmitted to man in several ways. The commonest mode of transmission is by direct contact with diseased birds or objects contaminated by excreta. Apparently healthy birds may be carriers and transmit the disease. Other modes of transmission include indirect transfer by air and also bite wounds.

The incubation period of psittacosis varies from seven to fourteen days with an average of ten days. The onset may be sudden with chilly sensations, fever, anorexia, sore throat, general malaise, and severe headache, or the presenting symptoms may be vague with a gradual and insidious onset. The disease has most often been confused with influenza, bronchopneumonia and typhoid fever.

Pulmonary involvement is an essential feature of human psittacosis except in especially mild cases. Focal pneumonia usually becomes established within the first few days of illness. Roentgen examination reveals a faint, usually circular, cloud of uniform density situated most often in one of the lower lobes. Scattered, patchy areas of consolidation frequently give this disease the appearance of a migrating pneumonia. Cough and expectoration are usually absent or slight. Nausea and vomiting are common. A relative bradycardia is a characteristic feature. Leukopenia is present in about 25 per cent of cases.

The diagnosis is based on history, symptoms, roentgen study and complement fixation test, and animal inoculation which can be done by the CDC Virus Laboratory through the State Board of Health Laboratory. Physicians desiring that specimens be examined for virus study should mark on the laboratory request slip that the virus examination is desired.

The death rate in human psittacosis has been markedly reduced since the introduction of penicillin and other antibiotics. The beneficial effects of aureomycin, terramycin and penicillin have been demonstrated.

This review of the latest information about psittacosis will be of particular interest to physicians because of the discovery, confirmed by laboratory tests, of psittacosis in fourteen psittacine birds in Dade and Broward counties during the past few months. Also two human cases are reported to have occurred in persons who contracted the disease from a bird purchased in Florida. Of interest to the profession is the fact that the victims were a physician and his wife. The medical profession of the state will undoubtedly want to exercise vigilance in recognizing any possible human cases. It is suspected that the disease among birds has been present in the area for some time without being recognized. It is fortunate that the antibiotic drugs constitute a satisfactory remedy for this serious and often fatal disease.

Study of Indigency of Persons Receiving State Aid for Treatment of Cancer

Frequent inquiries have been made concerning the methods and criteria used by the State Board of Health in determining to whom state aid should be given in its Cancer Control Program. For this reason a study of this subject was made during the fall of 1951. The study was directed by a qualified social worker, Mrs. Lamar Rozear of Jacksonville. For economy reasons it was decided to confine the survey to one hundred consecutive and unselected

cases which were certified in August 1951. These cases fell in thirty-nine different counties from Escambia to Monroe and ranged in population from the smallest to the largest.

Methods of determining indigency vary from county to county. The primary responsibility for determining indigency is placed upon the county health officer but he is encouraged to seek the assistance of state and local welfare agencies and the physicians who are treating the patient. Mrs. Rozear secured the assistance of qualified social workers and made a thorough study of the financial resources of every case that could be found. Such factors as current income, real estate, life insurance, automobiles, etc., were looked into.

The following is a summary of the findings made:

Incomes of Patients Fully Studied

Single persons	
Income $75 or less	4
Families (2 or more)	
$150 month or less	33
Families (2 or more)	
$150-200 monthly	5
Families (2 or more)	
$200-250 monthly	4
Families (2 or more)	
$250-325 monthly	5
Unknown	2
Public assistance recipients	40
Unable to locate	4
Deceased (financial circumstances unknown)	3
Total	100

The conclusion reached was that there were few, or no, persons in this group where medical indigency could be considered in doubt. The five patients with family incomes ranging from $250 to $325 monthly all were members of large families. Since forty of the one hundred persons had already been thoroughly investigated by the State Welfare Board it was not felt worthwhile to repeat their work.

Although the methods employed by the State Board of Health and county health departments for determining indigency are crude, and investigations are not made routinely by trained social workers, it is felt that it would not be worthwhile from a financial standpoint to change the methods now being used. It is estimated that it would cost at least $50,000 per year to have all prospective state aid patients investigated by social workers whereas the entire budget for Cancer Control is only about four times that amount. It is believed, however, that an occasional check such as that described above by qualified social workers is indicated. The survey that was made cost only about $1,200. A similar study is now being made of persons receiving insulin for diabetes .

BIRTHS AND DEATHS

Births

Dr. and Mrs. Leonard Garten of Jacksonville announce the birth of a son, Barry Arthur, on December 21.

Dr. and Mrs. George F. Schmitt, Jr., of Miami announce the birth of a daughter, Susan Lynn, on January 12.

Deaths — Members

Snow, Henry O., Tampa ..... Feb. 18, 1952
McDuffie, Harold F., Jacksonville ..... March 4, 1952

Deaths — Other Doctors

Buckner, Rufus G., Tampa ..... Recently.
Evans, Kline W., Columbia, Tenn. ..... Recently
Hilborn, Robert R., Midland, N. C. ..... Nov. 16, 1951

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Alsup, Fred W., (Col.), St. Petersburg
Anderson, James R., West Palm Beach
Bane, Russell C., St. Petersburg
Boyce, J. Clifford, Sanford
Bray, Walter A., St. Petersburg
Brown, Clyde M., Tampa
Buford, Edward T., Jr., (Col.), Panama City
Burns, Edward C., Jr., Lake Wales
Croom, William C., Jr., Jacksonville
Curry, Hiram B., Jasper
Debo, Raymond A., Eustis
Frazier, Truett H., Orlando
King, Samuel A., Avon Park
Knauer, William J., Jr., Jacksonville
McKell, Thomas E., Tampa
Meadows, Benjamin J., Jr., Dade City
Pope, Charles L., Tampa
Rogers, Lee, Jr., Cocoa
St. John, Joseph H., Jacksonville
Schoetker, George H., Clearwater
Smith, Lynwood B., Tampa
Tomlinson, Wray J., Jacksonville
Vaughan, Davis H., Clearwater
Wadsworth, Charles L., Ft. Lauderdale
Winstead, George A., Panama City

STATE NEWS ITEMS

The Florida Medical Association Smoker Committee for the annual meeting in April met in Hollywood, Sunday, February 24, with 100 per cent attendance. Present were Drs. Reuben B. Chrisman, Jr., chairman, Miami; Francis T. Holland, Tallahassee; Chas. J. Collins, Orlando; Lewis T. Corum, Tampa; and Curtis H. Sory, Fort Lauderdale. Also in attendance was Dr. Stewart G. Thompson of Jacksonville, managing director.

Dr. Joshua C. Dickinson of Tampa was elected Chancellor of the American College of Radiology at the annual meeting on February 8 in Chicago.

Dr. Walter C. Jones of Miami, president-elect of the Southern Medical Association, attended the meeting of the executive committee of the Council of the Southern Medical Association at the Hotel Nacional, Havana, Cuba, January 24. A diploma which expresses the esteem in which the members of the Southern Medical Association are held by the physicians of Cuba and an appreciation of the professional brotherhood between physicians of the United States and Cuba was presented to each officer of the Southern Medical Association attending the meeting, by the Cuban Medical Association and the Havana Medical Association.

Dr. John P. Michaels of Orlando was the main speaker at a recent program meeting of the Pilot Club of that city. Dr. Michaels, president of the Central Florida Mental Hygiene Society, told the history of the society and stressed the need for education to aid in the mental problem.

Dr. Herbert L. Bryans of Pensacola was re-elected president of the Florida State Board of Health for a twelfth term at the board's annual session in Jacksonville, February 11-13.

Dr. Jack Q. Cleveland of Coral Gables represented Florida in Chicago, February 17, at the "Kick-off" Conference of the 1952 drive for funds by the American Medical Education Foundation.

Dr. Nathan Weil, Jr., of Jacksonville attended a course on the care of the Premature Infant at New York Hospital in January.

Two members of the Florida Medical Association have been appointed by State Superintendent of Public Instruction, Thomas D. Bailey, to a newly formed state advisory committee on practical nursing to assist in operation of a practical nurses training program in the state. Representing the Florida State Board of Health is Dr. Herbert L. Bryans of Pensacola, and representing the Florida Medical Association is Dr. Jere W. Annis of Lakeland.

Dr. George R. Gage of Miami spoke to members of the Cerebral Palsy Parents Council of the Dade County Society for Crippled Children recently at the clinic.

Dr. Joseph L. Kinzie of Lake Wales was among speakers who discussed their professions at the Career Day program at Lake Wales High School recently. In discussing the profession of medicine, Dr. Kinzie stressed the fact that a doctor's time is never his own, and that he must be ready to give his time, have an interest in people, and want to help them.

Dr. Joseph S. Stewart of Miami will preside at the joint meeting of the Southeastern Surgical Congress and The Atlanta Graduate Medical Assembly in Atlanta, March 10-13. Registration for both assemblies is $15. For information, write Mrs. S. R. Roberts, Executive Secretary, 768 Juniper St., N.E., Atlanta.

The Second Annual Seminar of the Dade County Pediatric Society will be held at the Jackson Memorial Hospital, Miami, April 23-25, 1952. Registration fee for non-members is $10. For information write Dr. W. S. Nock, 273 Alhambra Circle, Coral Gables.

Dr. James C. Lanier of Jacksonville spoke on various phases of pediatrics at a recent meeting of the Southside Junior Woman's Club of that city.

Dr. Robert O. Burry of DeLand answered questions about diseases of the heart on a recent special program over radio station WJBS. The address was one of a series arranged in conjunction with the Heart Drive.

Dr. Roger E. Phillips of Orlando discussed a medical film, "That Angry Boy," at the regular monthly meeting of the Florida Nurses Association, District 48, in January.

Dr. Ernest R. Bourkard of Tampa spoke on "Electric Shock Therapy," at the regular January meeting of the Tampa Bay Psychological Association.

The Eighteenth Annual Meeting of the American College of Chest Physicians will be held at the Congress Hotel, Chicago, June 5 through 8, 1952. A scientific program covering all recent developments in the treatment of heart and lung disease is being arranged.

Dr. M. Jay Flipse of Miami is Regent of the College for the district and Dr. Clarence M. Sharp of Jacksonville serves as Governor of the College for Florida. Officers of the Florida Chapter of the College are Dr. Howard K. Edwards, president, and Dr. Nathaniel M. Levin, secretary-treasurer, both of Miami.

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held in Chicago on June 5, 1952. Candidates for Fellowship in the College who wish to take the examinations should contact the Executive Secretary, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11.

Dr. Carlos P. Lamar of Miami attended the International Conference on Vitamins and Metabolism held in Havana, Cuba, February 23-26. The Conference was sponsored by the University of Havana in conjunction with Northwestern University, Chicago, and the Nutritional Clinic, Birmingham, Ala.

Dr. James T. Hardy of Lake Worth spoke on the various types of heart conditions and their symptoms at a recent meeting of the Carl Vogel-Donald Lee Post 47, American Legion, of Lake Worth.

Dr. Joseph L. Selden, Jr., of Fort Myers spoke at a recent meeting of the Lee County Cancer Society.

Dr. Joe F. Garner, formerly of Jacksonville, announces the opening of his offices in Dothan, Ala.

The Committee on Medical Motion Pictures has completed the 1951 supplement to the second revised edition of the booklet entitled "Reviews of Medical Motion Pictures." This supplement contains 90 reviews of medical and health films reviewed in The Journal of the A. M. A. from Jan. 1, 1951, through Dec. 31, 1951. Each film has been indexed according to subject matter. The purpose of these reviews is to provide a brief description and an evaluation of motion pictures which are available to the medical profession.

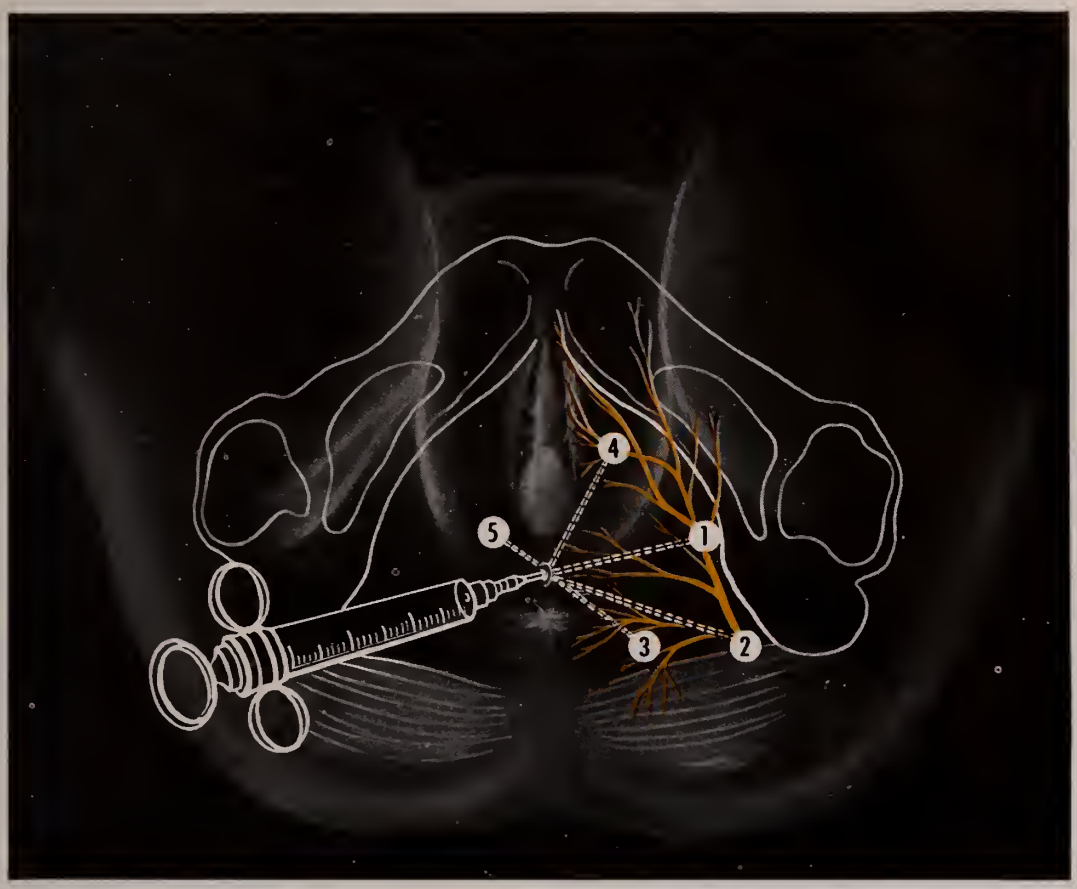
A study of children's diseases and their occurrence in Florida has been initiated by the Florida Heart Association and the Florida Pediatric Society. A committee to undertake the study has been appointed by Dr. Egbert V. Anderson of Pensacola, president of the Florida Pediatric Society, and Dr. Elwyn Evans of Orlando, president of the Florida Heart Association. Members of the committee are Drs. Edward L. Cole, Jr., and James L. Gouaux of St. Petersburg; Lewis T. Corum and H. Phillip Hampton of Tampa; and James M. Stem of Clearwater and John A. Mease, Jr., of Dunedin.

Dr. Edward R. Annis of Miami spoke at the second annual banquet of the ten classified women's service clubs of the Miami area. His subject was "Brains in the Stockpile."

Dr. Benjamin F. Barnes of Chattahoochee was presented a plaque by the Woodmen of the World at an oyster supper given by the Chattahoochee Magnolia Camp 228. The plaque award was presented to Dr. Barnes in recognition of his outstanding service as a doctor and citizen in Chattahoochee for the past 50 years.

Dr. William M. Davis of St. Petersburg, who has practiced in that city longer than any other physician in Pinellas County, recently marked the forty-fifth anniversary of his start in medicine in St. Petersburg.

(*Continued on page 740*)



Sites for injection of local anesthesia in obstetrics. Sites 1 to 4 should be similarly injected on the contralateral side. Site 5 is for episiotomy. Adapted from Johnson, O. J.: Nerve Block in Painless Childbirth, J.A.M.A. *145*:401 (Feb. 10) 1951.

Pudendal Block in Obstetrics Simplified with **ALIDASE**

Using a local anesthetic with hyaluronidase, Heins[1] reports: "Complete perineal anesthesia is practically instantaneous. . . . The technique of pudendal block is greatly simplified. The operator does not have to inject the nerve per se, but infiltration in the vicinity of the nerve will accomplish an effective block."

Baum[2] states: "The use of hyaluronidase is found to be a safe and simple method for increasing the efficiency of pudendal block in obstetrics and for overcoming many of the objections to this type of obstetrical anesthetic."

ALIDASE®—highly purified, well tolerated brand of hyaluronidase—definitely shortens the period between completion of the block and establishment of operating analgesia. Swelling, induration and discomfort are almost negligible with Alidase.

[1]Heins, H. C.: Pudendal Block with Hyaluronidase, J. South Carolina M. A. *46*:309 (Oct.) 1950.

[2]Baum, F. E.: The Use of Hyaluronidase in Pudendal Block, Am. J. Obst. & Gynec. *60*:1356 (Dec.) 1950.

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Therapy for Vascular Headache to Reverse the Physiologic Disturbance

Headache, a problem encountered in all kinds of medical practice, may occur in association with any of a variety of disorders, some organic, other purely functional.

Among the several types, functional headaches present the greatest problem because of their obscure etiology and recurrent nature.

Among these are:

Migraine (both classical and variant forms)
Tension headache
Psychogenic headache
Histaminic cephalgia

Wolff and his co-workers established that the pain of these headches is due to disturbance of the tonus of cranial blood vessels — hence the term *vascular headaches.*

The craniovascular changes associated with the several phases of the typical migraine attack are:

Vasoconstriction — to which the visual prodromata are attributable. It is possible to abort the attack during this phase in all but a few cases. (See treatment below.)

Vasodilatation — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

Vessel Edema — if the vasodilation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

Therapy: 1. Reduce the frequency of attacks — psychotherapy and regulation of living habits to avoid fatigue and nervous tension.

2. Relieve the acute attack — of the numerous drugs which have been tried, ergotamine and its derivative preparations have proved most effective. The newest product is oral tablets of Cafergot®, N. N. R. (ergotamine with caffeine 'Sandoz'). When dosage is adjusted to the needs of the individual, Cafergot will give good relief in 85% of cases. It enables a greater number of patients to benefit from early administration since the oral route simplifies treatment as compared to parenteral therapy.

The dosage procedure is:

1. Take 2 tablets at first sign of the attack.
2. If attack continues, take one additional tablet every ½ hour until attack is terminated *(max. 6 tabs. per attack).*

Many migraine patients delay taking medication until the attack is at its height. Explicit dosage instructions may be forgotten unless the patient comes to realize their importance. Therefore, to encourage adherence to correct procedure, we have prepared pads outlining detailed dosage instructions. Supplies of these INSTRUCTION SLIPS will gladly be sent upon request.

GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull *54:* 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Wolff, H.: Headache and Other Head Pain, N. Y., Oxford Univ. Press, 1948.

Sandoz Pharmaceuticals
DIVISION OF SANDOZ CHEMICAL WORKS, INC.
68 CHARLTON STREET, NEW YORK 14, N. Y.

(Continued from page 738)

Dr. Paul F. Hutchins of Jacksonville is at Tulane University of Louisiana School of Medicine for a year's study in Orthopedic Surgery and Adult Reconstruction.

Dr. Oscar L. Kelley of Palm Beach spoke on "Practical Aspects of Geriatric Nursing" at a recent semi-monthly meeting of Licensed Practical Nurses, Division 1.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per Insertion for ads of 25 words or less. Add 20c for each additional word.

LOCATION DESIRED: Surgeon, F. A. C. S. and Board eligible, age 37, desires Florida location. Will consider association with older surgeon, community needing general surgeon or industrial position permitting some private practice. Capable and well trained. Best of references. Florida license. Write 69-62, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: Florida — Jacksonville — Lucrative E. E. N. T. practice for sale by Estate. Established over forty years. Equipped offices in downtown building. Write 69-63, P. O. Box 1018, Jacksonville, Fla.

PHYSICIAN WANTED: White, gentile, American born, protestant, grade A graduate, internship and at least one year surgical residency. Real opportunity with rapid advancement. Located in Central Florida. Write 69-64, P. O. Box 1018, Jacksonville, Fla.

PHYSICIAN WANTED: Resident House Physician required at New England's largest summer resort hotel, the Mount Washington Hotel, Bretton Woods. New Hampshire. Season—July 1st to September 10th. Please communicate with Oscar T. Johnson, Managing Director, at Homosassa Springs Hotel, Homosassa Springs, Fla.

PHYSICIAN WANTED: Young or middle aged, general practitioner, for county-seat town. Reason for needing physician: My age and heavy work. Write O. F. Green, M.D., Mayo, Fla.

NOTICE

Your March Journal carried a complete program and other detailed information relative to the Seventy-Eighth Annual Meeting of the Association in Hollywood, April 27-30.

COMPONENT SOCIETY NOTES

Bay

At the regular meeting of the Bay County Medical Society in February, Dr. George S. Tootle, surgeon from Hartford, Ala., reported on the meeting of the American College of Surgeons held in Brimingham in January and presented some of the information and ideas developed there.

Dade

At the March meeting of the Dade County Medical Association, papers were presented on "Pitfalls of 'Routine' X-Ray Examination." Dr. Richard D. Shapiro spoke on "The Chest;" Dr. Oliver P. Winslow, "The Skeleton;" Dr. Maurice M. Greenfield, "The Abdomen;" and Dr. Eugene H. Bryson, "The Gastro-Intestinal Tract."

Duval

At the regular monthly meeting of the Duval County Medical Society in March, Drs. Eugene M. Frame, J. K. David, Jr., and Ivan Isaacs presented a paper on "Discussion of Scurvy as Seen in Jacksonville Area."

Escambia

Members of the Escambia County Medical Society were among the speakers at a five-day institute on nursing care for the polio patient held March 3-7 at Crippled Children's Home in Pensacola.

Lake

At the regular monthly meeting of the Lake County Medical Society in February, Drs. Lorenzo L. Parks and William A. Walter of the Florida State Board of Health, Jacksonville, spoke on "Serology Tests." The wives were guests of the members at this meeting, and the organization of the Woman's Auxiliary was completed.

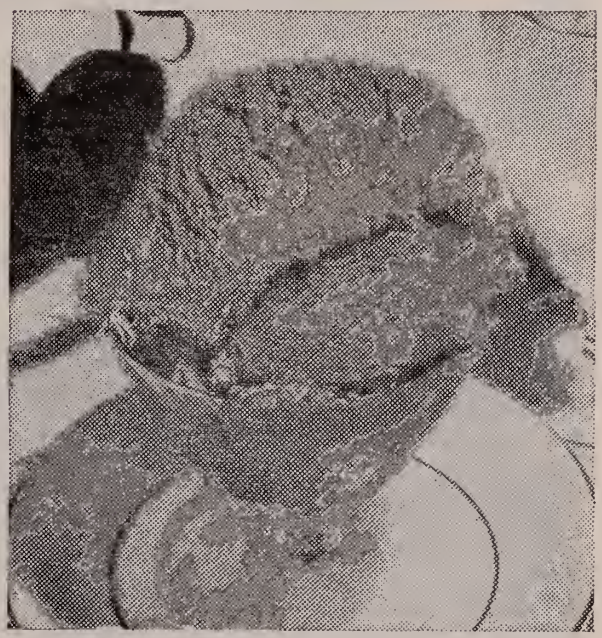
Monroe

Members of the Monroe County Medical Society met with the medical staff of the U. S. Naval Hospital at Key West for the regular February meeting. Dr. D. J. Leithauser of Detroit spoke on "Early Ambulation in the Prevention of Postoperative Pulmonary Embolism," and the paper was discussed by Dr. John M. T. Finney, associate professor of surgery, Johns Hopkins University School of Medicine.

(*Continued on page 742*)

Rx

...FOR BOTH DOCTOR AND PATIENT



• The name Sealtest is your guarantee of rich, wholesome dairy foods—healthful refreshment at its nourishing best.

Southern Dairies
Sealtest
ICE CREAM

(*Continued from page 741*)

Pinellas

Mr. Jefferson Hamilton addressed the Pinellas County Medical Society at its regular monthly meeting on March 3. His subject was "The Proposed University of Florida Medical Center."

Dr. Wesley W. Wilson of Tampa spoke on Dermatology at the April meeting.

Members of the Pinellas County Medical Society recently were invited to a special showing of the professional film, "Uterine Cancer: The Problem of Early Diagnosis," at the Pinellas County Tumor Clinic. The film was brought to St. Petersburg by the American Cancer Society.

Sarasota

At the regular February meeting of the Sarastoa County Medical Society, the Society endorsed the campaign of the Sarasota Heart Committee, which was conducting a fund-raising drive in cooperation with the American Heart Association.

Seminole

All members of the Seminole County Medical Society have paid their state dues for 1952.

Volusia

Dr. John J. Cheleden of Ocala addressed the regular meeting of the Volusia County Medical Society in Daytona Beach in February.

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Aveeno provides prolonged emollient action on irritated skin areas . . . controls pruritus ani and pruritus vulvae . . . relieves itching and skin irritation in general rashes, sulfa and penicillin rashes, eczemas and allergic reactions.

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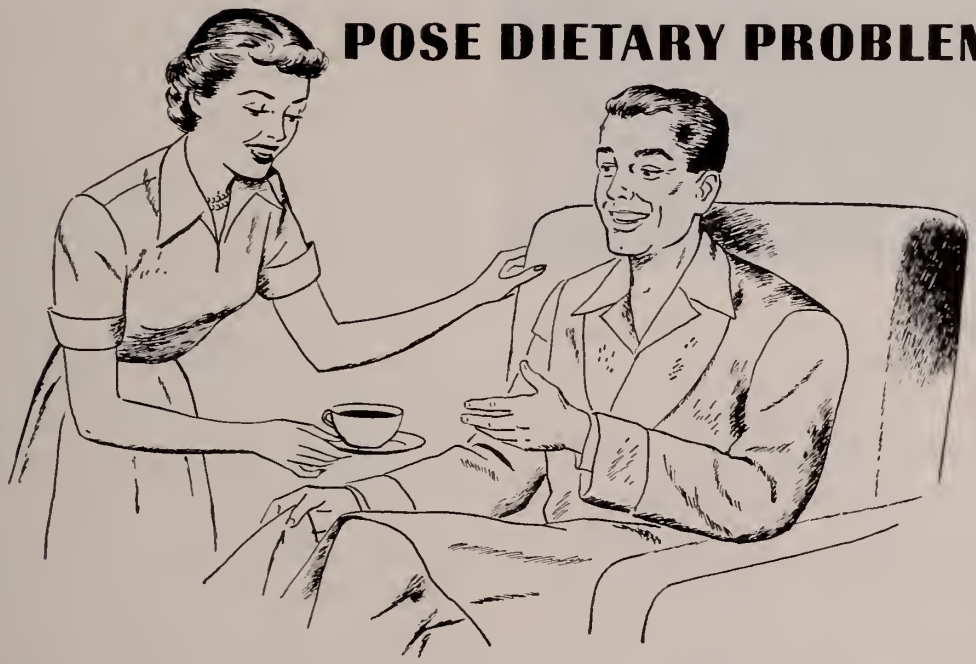
Thoroughly modern in architecture and construction. Eight departments — affording proper classification of patients. All outside rooms attractively furnished. Several bathrooms and rooms with private bath on each floor. Also a spacious sun parlor in each department. Located on the crest of Higdon Hill, 1,050 feet above sea level, overlooking the city, and surrounded by an expanse of beautiful woodland. Ample provision made for diversion and helpful occupation. Adequate night and day nursing service maintained. Catalogue sent on request.

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POSE DIETARY PROBLEMS



In the interest of maintaining good nutrition in the patient, many functional derangements of the gastrointestinal tract make the use of a well rounded dietary supplement, such as Ovaltine in milk, highly advantageous. Among such functional derangements more commonly encountered are nausea, anorexia, gastritis, diarrhea, dysentery, enteritis, and colitis.

In these conditions, Ovaltine in milk is particularly useful, not only because of its easy digestibility but also because of its blandness and its high nutrient content. It offers the opportunity of providing a balanced fare of essential nutrients without mechanical irritation or excessive digestive demands. Hence it qualifies especially when customarily eaten foods are contraindicated and a nutritious bland diet is required.

The wealth of nutrients supplied by three glassfuls of Ovaltine in milk is outlined in the table below.

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PHOSPHORUS	940 mg.	THIAMINE	1.2 mg.
		CALORIES	658

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OBITUARIES

John A. Stanford

Dr. John A. Stanford of Fort Lauderdale died at his home there on Dec. 27, 1951, after a lingering illness. He was 76 years of age.

A native of Florida, Dr. Stanford was born in Columbia County on April 26, 1875. He received the degree of Doctor of Medicine from the Medical College of the State of South Carolina at Charleston in 1909. Immediately thereafter, he returned to Florida and began the practice of medicine in Dunnellon. Four years later he moved to Fort Lauderdale, becoming one of the first physicians to serve that area. At that time, Fort Lauderdale was little more than a flag station on the railroad, headquarters for the Bass Fisheries and a trading post for the Seminole Indians. Soon the Florida East Coast Railway appointed Dr. Stanford as railroad physician, a post which he held for many years. As a general practitioner, he pursued his profession faithfully and well and was held in high esteem by early settlers and Indians alike. After twenty-nine years of medical practice in his native state, he was forced to retire in 1938 because of ill health.

Being civic-minded, Dr. Stanford was active in promoting the growth of Fort Lauderdale. As early as 1925 he served as president of the First National Bank and for many years was a member of its board of directors. He also was vice president of the Pioneer Department Store. A charter member of the local Elks Lodge, he was in addition a Mason and a member of the First Methodist Church, where for years he sang in the choir.



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When the Broward County Medical Society was organized in April 1926, Dr. Stanford was a charter member. Two years later he served as its president. Following his retirement from active practice, he became an honorary member of this society and also of the Florida Medical Association and the American Medical Association.

Survivors include two daughters, Miss Vera Stanford and Mrs. Alvarez Putt of Fort Lauderdale; two sons, Dr. H. B. Stanford of Hartwell, Ga., and Kramer Stanford of Miami; and three grandsons, John W. Stanford, a student at the University of Florida, and James Sterling Whisenhunt and Neil Stanford Whisenhunt, both of Fort Lauderdale.

James Fling Pitman

Dr. James Fling Pitman died on Jan. 31, 1952 at his home in Lake City after a long illness. He was 61 years of age.

Born in LaGrange, Ga., on June 14, 1890, Dr. Pitman was educated in his native state. In 1913 he received his medical degree from the Atlanta College of Physicians and Surgeons. During World War I he served as a captain in the United States Army.

After practicing for a number of years in Atlanta, Ga., Dr. Pitman moved to Lake City in 1933 to become associated with the Veterans Administration Hospital there. Radiology was his specialty, and in 1942 he resigned from the Veterans Administration to enter the private practice of radiology in Lake City.

In war and in peace, Dr. Pitman served his community, his state and his nation well and was held in highest esteem by his fellow citizens and his colleagues. He was a member of the Veterans of Foreign Wars, the American Legion and the Lake City Rotary Club.

Dr. Pitman was a past president of the Columbia County Medical Society, in which he had held membership for fifteen years. He was a member of the Florida Medical Association and the American Medical Association. A past president of the Florida Radiological Society, he was also a fellow of the American College of Radiology and the Radiological Society of North America.

Surviving are the widow, Mrs. Fannie Oliver Pitman, and a son, James H. Pitman, both of Lake City; a daughter, Mrs. C. C. McMurtry of Kansas City, Mo.; and a sister, Miss Anna May Pitman of Bangor, Me. Two grandchildren also survive.

Advertisement



From where I sit
by Joe Marsh

They Do "Give A Hoot" For Easy

Easy Roberts finally got rid of the noisy pigeons that used to whoop it up under his eaves.

He must have tried a dozen ways to scare them off. But no matter what he did, they would be right back cooing by his window the next morning.

Then Easy thought of an old stuffed owl he had in his attic. He propped it on the roof so's all the pigeons could see it. They left . . . and three hoot owls have taken their place. Easy swears the hooting is even worse than the cooing of the pigeons.

From where I sit, bright ideas often turn out to be "not so bright." That's why we shouldn't be too positive about our own opinions. Some people like to tell their neighbors who to vote for, how to practice their profession, even what beverage to choose. I believe a glass of beer is the best thirst-quencher—you may believe differently. But who's to say one's right and the other is wrong? Let's just practice tolerance. It'll save a lot of hootin' and hollerin'.

Joe Marsh

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	Coral Gables	3028 Biscayne Blvd.	
	Miami Beach	3028 Biscayne Blvd.	
St. Petersburg		515 White Building	
Lakeland		206 Marble Arcade	
West Palm Beach		410 Datura Street	
Orlando		209 Slayton Building	
Fort Lauderdale		521½ South Andrews Avenue	
Jacksonville		303 Clark Building	
Tampa		228 Cass Street Arcade Building	
Sarasota		237 Main Street, Room 15	
Fort Pierce		Florida Bank Building, Room 34	
Daytona Beach		116½ Orange Avenue	
Tallahassee		429 Centennial Building	
Panama City		142 Harrison Avenue	
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The Brook Haven Manor Sanitarium announces the opening of its annex for the reception of geriatric patients and the elderly.

Brook Haven Manor Sanitarium
Stone Mountain, Georgia

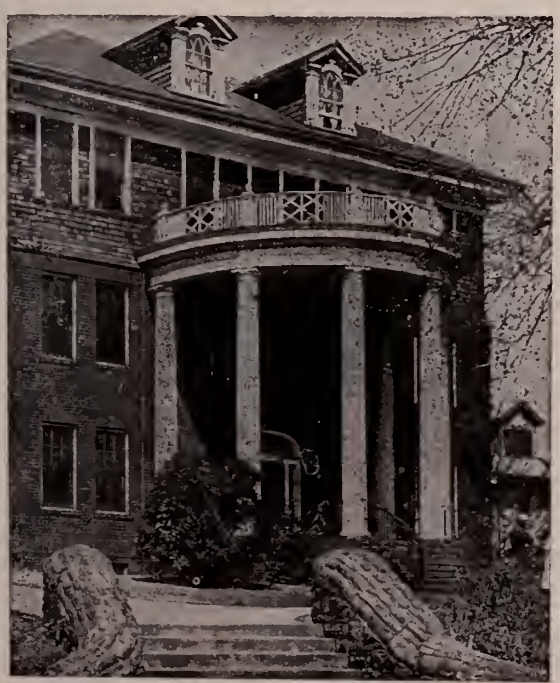
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GYNECOLOGY—Intensive Course, Two Weeks, starting April 21, June 16. Vaginal Approach to Pelvic Surgery, One Week, starting May 5, June 9.

OBSTETRICS—Intensive Course, Two Weeks, starting April 7, June 2.

PEDIATRICS—Intensive Course, Two Weeks, starting April 7. Informal Clinical Course every two weeks. Cerebral Palsy, Two Weeks, starting July 7.

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UROLOGY—Intensive Course, Two Weeks, starting April 28. Ten Day Practical Course in Cystoscopy starting May 12, May 26.

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This space is reserved for the usual monthly advertisement of Hoye's Sanitarium, Meridian, Mississippi pending change of name and preparation of appropriate advertising matter. The name of the institution was changed on January 14, 1952, to THE EARLE JOHNSON SANATORIUM.



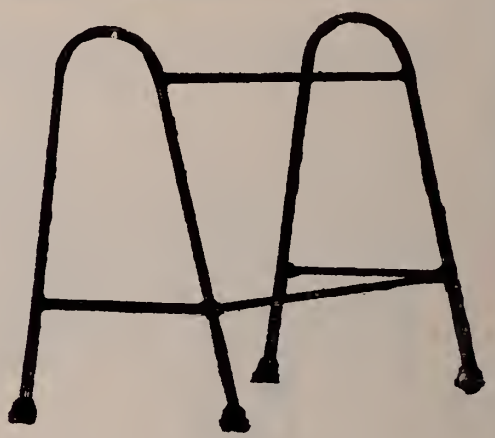
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
rida Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	Hollywood, Apr. 27-30, '52
rida Medical Districts	William C. Roberts, Panama City	Council Chairman	
-Northwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Panama City, 1952
-Northeast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Daytona Beach, 1952
-Southwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	St. Petersburg, 1952
-Southeast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Ft. Pierce, 1952
rida Specialty Societies			
demy of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	Hollywood, Apr. 27, '52
rgy Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	" "
sthesiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	" "
pter, Am. Coll. Chest Phys	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	" "
m. and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	" "
lth Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	" "
rt Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	Miami, May 8-10, '52
ustrial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	Hollywood, Apr. 27, '52
rology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
and Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	" "
thal & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	" "
hopedic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	" "
iety of Pathologists	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Lauderdale	" "
iatric Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	" "
ctologic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	" "
liological Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	" "
ological Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	" "
rida—			
asic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 7, '52
lood Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
lue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
lue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 27, '52
ancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
ental Society, State	John I. Todd, D.D.S., Jacksonville	Tom Price, D.D.S., Miami	Jacksonville, Apr. 20-23, '52
lospital Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Beach, Nov. '52
ledical Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	Jacksonville, June 29-July 1, '5
ledical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 23-28, '52
urses Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
harmaceutical Association, State	Mr. Euless Watford, Chipley	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-21, '52
ublic Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct., '52
uberculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Pt. St. Joe	Daytona Beach, May 15-17, '52
oman's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	Hollywood, Apr. 27-29, '52
erican Medical Association	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Chicago, June 9-13, '52
.M.A. Clinical Session	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
thern Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, 1952
abama Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	Montgomery, Apr. 17-19, '52
orgia, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 11-14, '52
E. Hospital Conference	Edwin B. Peel, Atlanta	Mr. R. G. Ramsey, Jr., Memphis	Atlanta, Apr. 16-18, '52
utheastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath. B. MacInnis, Columbia, S. C.	
utheastern, Am. Urological Assn.	Temple Ainsworth, Jackson, Miss.	Russell B. Carson, Ft. Lauderdale	Boca Raton, Apr. 2-5, '52
utheastern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
lf Coast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct., '52

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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS		COUNCILOR
					Total	Paid	
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		23	11	
	Escambia **Santa Rosa*	Chas. J. Heinberg, M.D. 109 N. Baylen St. Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	73	60	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	William P. Blackmon, M.D. Apalachicola	Last Wednesday	8	7	
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	16	12	A-1-52 Arthur J. Butt, M.D. Pensacola
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	15	
	Washington-Holmes	George W. Carter, M.D. Chipley	Bayllye W. Dalton, M.D. Chipley		6	100%	
	Columbia **Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	13	11	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	56	7	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		9	5	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		4	3	
	Taylor **Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	1	228
B	Alachua **Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	49	47	
	Duval **Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	251	149	
	Marion **Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	28	14	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	9	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	11	7	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	14	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	22	17	
	Lake **Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	27	21	
	Orange **Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	151	113	B-4-53 Eugene L. Jewett, M.D. Orlando
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	100%	
	Volusia **Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	78	55	658
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	170	135	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	19	14	
	Pasco-Hernando- Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	15	10	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	184	174	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	41	6	
	DeSoto-Hardee- Highlands- Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	26	21	
	Lee-Charlotte- Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	25	24	C-6-52 Leldon W. Martin, M.D. Sebring
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	91	77	571
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	1	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	117	105	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	St. Lucie- Okeechobee- Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	7	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	81	65	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	590	379	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	James B. Parramore, M.D. Box 326 Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	12	11	822

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Vol. XXXVIII MAY, 1952 No. 11

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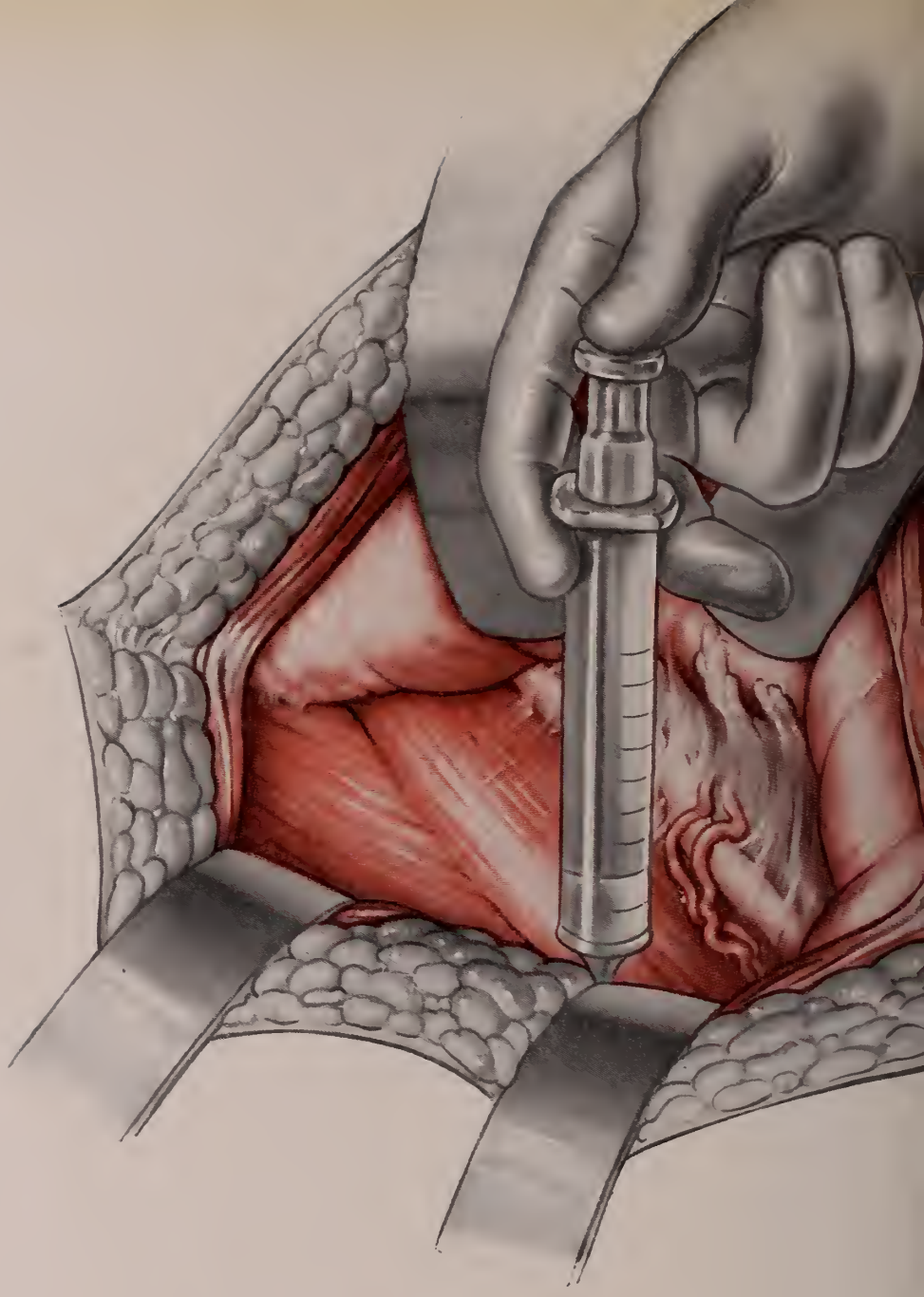
Intramedullary Pin Fixation
Wendell J. Newcomb

Diseases of Parotid Gland
G. Dekle Taylor

Enlarged Prostate, Its Surgical Management
S. Joseph Pearlman

Gifts to A. M. E. Foundation
An Editorial

OFFICIAL PUBLICATION OF THE
FLORIDA MEDICAL ASSOCIATION



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Volume XXXVIII MAY, 1952 No. 11

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Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

Meat and its applicability in the Dietary Management of Atherosclerosis

Contrary to the former belief that serum cholesterol levels are primarily related to ingested animal fat and consequently to dietary cholesterol, it now appears that the total amount of fat in the diet, not its source or cholesterol content, is a more important factor in determining the blood cholesterol concentration.[1,2,3,4] Clinical observation has shown that ingestion of vegetable fat—which contains no cholesterol—will, like fats of animal origin, raise the serum cholesterol level.[3, 5]

Recent basic research on the influence of fats and cholesterol on human health has done much to further progress in the fight against atherosclerosis. It will serve well in dispelling the mistaken fear that reasonable amounts of foods of animal origin predispose the individual to this vascular disease.[6] As a matter of fact, a dietary inadequate in essential nutrients but providing too many calories and too much fat from *any* source may well be an important factor underlying the deposition of fat and cholesterol in the arteries and liver.

Cumulative evidence indicates that lowered blood levels of cholesterol may be effected by restricting the total fat intake.[1] Except in instances of refractory hypercholesteremia, in which a daily fat intake as low as 10 Gm. may not reduce cholesterol levels to normal, diets containing 20 to 30 Gm. of fat, or even more, often produce low cholesterol blood levels. In the clinical application of this principle, various palatable, low fat diets which supply three servings of meat daily (containing 18 Gm. of fat) have recently been suggested for the dietary management of arteriosclerosis and for enlisting the cooperation of patients.[1] The meat servings were chosen from a large variety of cuts and kinds of meat (fat trimmed off, as lean as possible). Meat adds to the eating appeal of the fat-restricted diet and contributes important amounts of biologically complete protein, the B group of vitamins including B_{12}, and food iron—all of which are important for a good state of nutrition in the atherosclerotic patient.

1. Hildreth, E.A.; Hildreth, D.M., and Mellinkoff, S.M.: Principles of a Low Fat Diet, Circulation *4*:899 (Dec.) 1951.
2. Bloch, K.: The Intermediary Metabolism of Cholesterol, Circulation *1*:214 (Feb.) 1950.
3. Keys, A.; Mickelson, O.; Miller, E.V.O., and Chapman, L.B.: The Relation in Man Between Cholesterol Levels in the Diet and in the Blood, Science *112*:79, 1950.
4. Gubner, R., and Ungerleider, H.E.: Arteriosclerosis, a Statement of the Problem, Am. J. Med. *6*:60, 1949.
5. Hildreth, E.A.; Mellinkoff, S.M.; Blair, G.W., and Hildreth, D.M.: The Effect of Vegetable Fat Ingestion on Human Serum Cholesterol Concentration, Circulation *3*:641 (May) 1951.
6. King, C.G.: Trends in the Science of Food and Its Relation to Life and Health, Nutrition Rev. *10*:1 (Jan.) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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Blahey, P. R.: Canad. M.A.J. 66:151 (Feb.) 1952.

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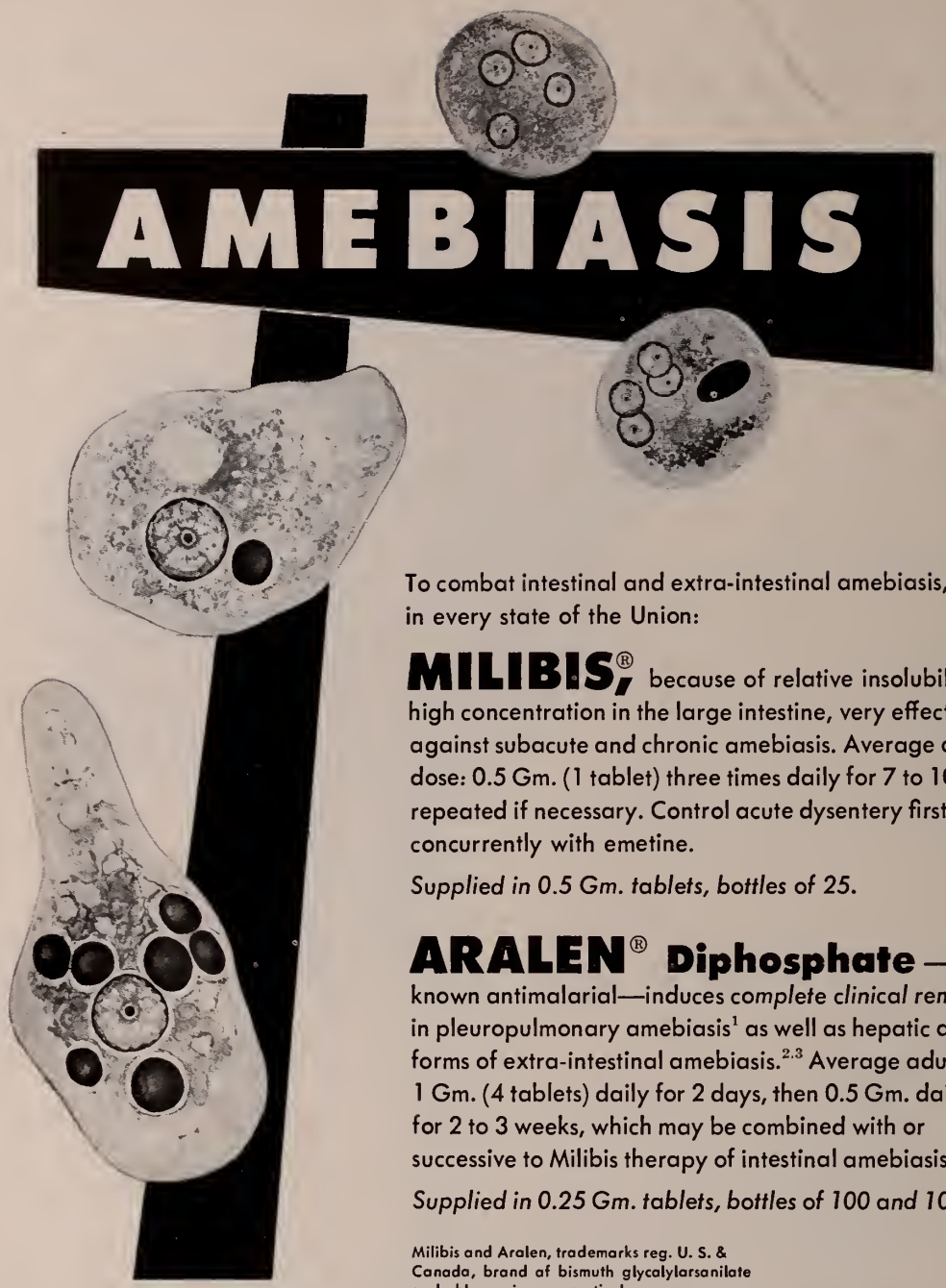
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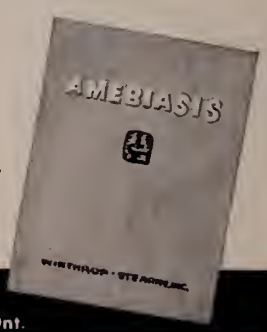
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1. Lindsay, A. E., Gassard, W. H., and Chapman, J. S.: *Dis. Chest*, 20:533, Nov., 1951.
2. Canan, N. J., Jr.: *Am. Jour. Med.*, 6:309, Mar., 1949.
3. Emmett, J.: *J.A.M.A.*, 141:22, Sept. 3, 1949.

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references:

1. Journal-Lancet 70:298, 1950.
2. Rocky Mountain M. J. 48:99, 1951.
3. Am. J. M. Sc. 218:298, 1949.
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12. Circulation 1:508, 1950.

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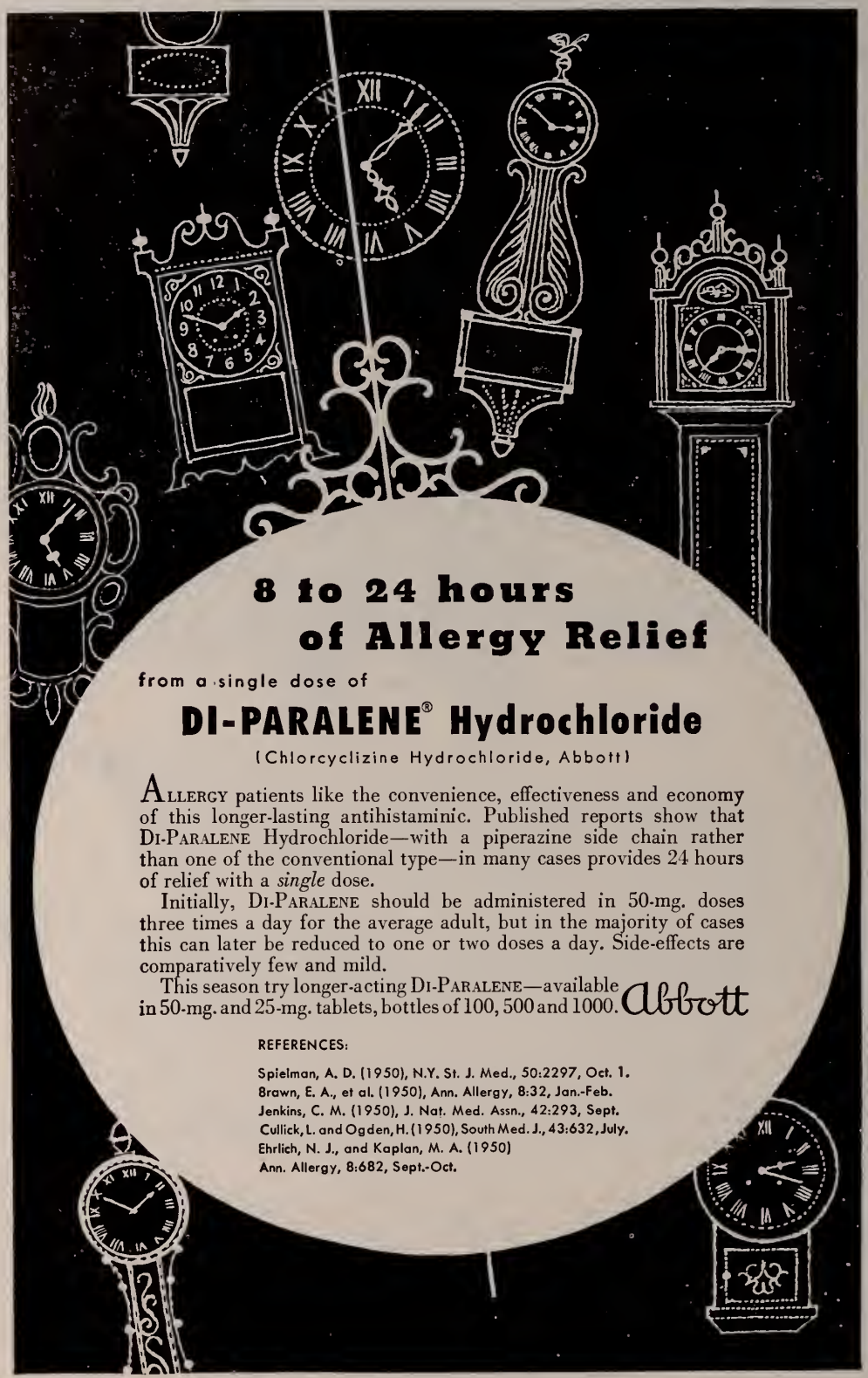
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REFERENCES:

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Ehrlich, N. J., and Kaplan, M. A. (1950)
Ann. Allergy, 8:682, Sept.-Oct.



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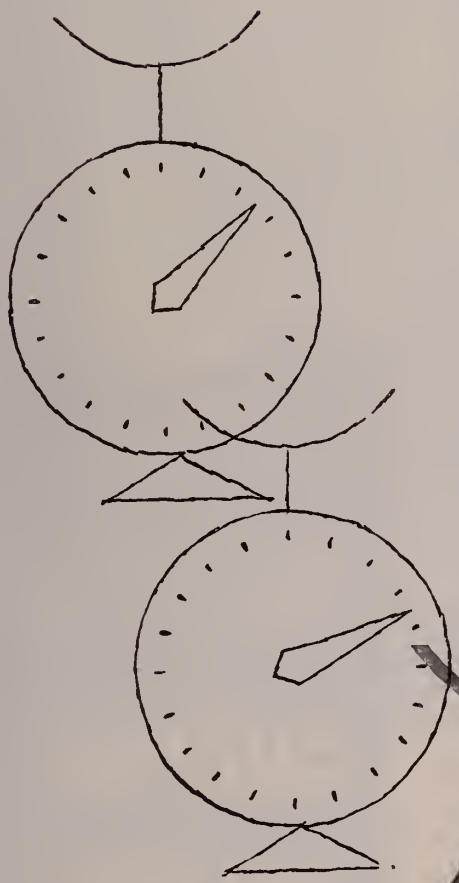
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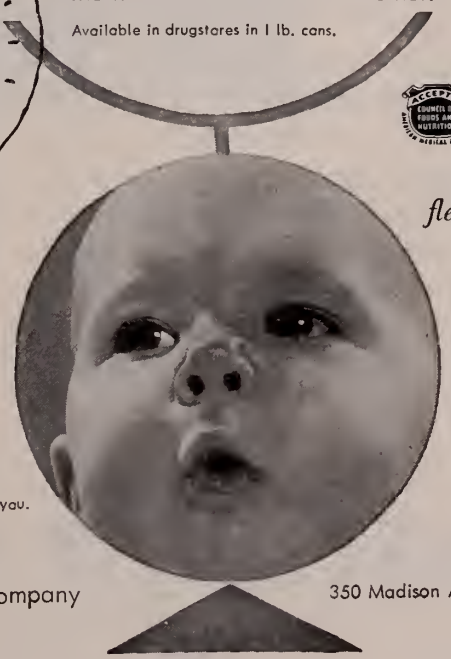
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1 Gardner, L. I., Butler, A. M., et al.: Pediatrics 5:228, 1950
2 Nesbit, H. T.: Texas State J. M. 38:551, 1943
3 Bull. National Research Council No. 119 Jan. 1950
4 Recommended Daily Dietary Allowances, Revised 1948, Food and Nutrition Board, National Research Council

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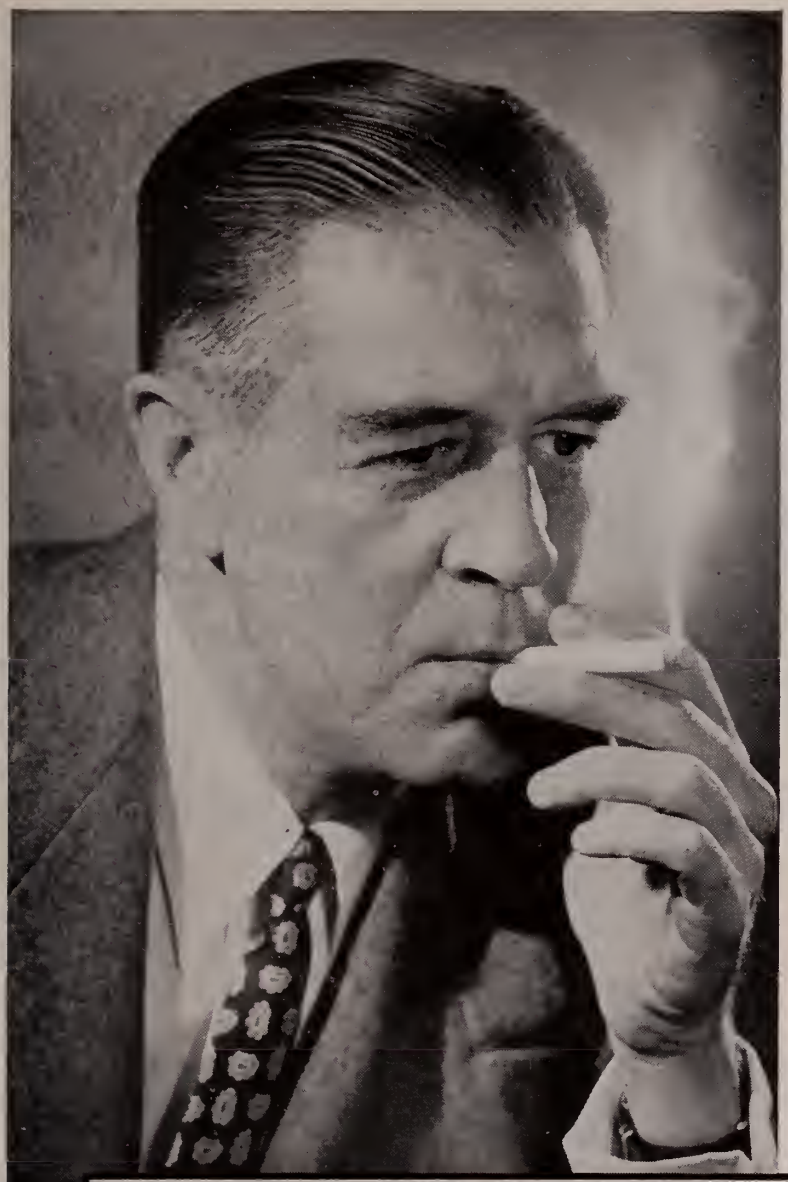
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PUBLISHED MONTHLY

Volume XXXVIII | Jacksonville, Florida, May, 1952 | No. 11

Intramedullary Pin Fixation in Femoral Fractures

WENDELL J. NEWCOMB, M.D.
PENSACOLA

A small series of 9 cases of application of the intramedullary pin in the femoral shaft is presented to outline the greatly improved method of treating this fracture. This method was endorsed by the Fracture Committee of the American Board of Orthopedic Surgery in 1949. It was then stated by Dr. Mather Cleveland that intramedullary fixation was the method of choice in treating fractures of the femoral shaft 2 inches below the lesser trochanter and 4 inches above the condyles. Many thousands of intramedullary pins have been applied since this statement was made, and remarkable results have been obtained, but much has been learned about complications of this apparently simple method.

Any fracture in the area mentioned by Dr. Cleveland may be handled in this manner. Usually the patient is placed in balanced traction prior to the insertion of the pin. This gives the patient time to overcome the original shock. Also, the surgeon has an opportunity to study the patient and build up his protective factors against infection. The pins have been inserted immediately in cases of compound fracture, but as shown in case 8 (table 1 and fig. 9), a more conservative method may be followed by allowing the original debridement wound to close prior to the fixation operation. Comminuted fractures may be held in place by circular wire, nylon or silk, or screws may be placed in the cortex of the bone adjacent to the pin in the medullary canal. Strong callus must be present before weight-bearing is allowed in comminuted fractures, or shortening may occur. Such shortening is demonstrated in the 47 year old patient in case 2 (table 1 and fig. 3), who walked before permission was granted.

The instruments used for nailing depend on the type of nail used. In all of the cases of this series the Hansen Street nail was employed. The equipment and nails are shown in figure 1. There are several problems; one, the length of the nail; two, the diameter of the intramedullary canal; and three, the contour of the femoral shaft.

The measurements of the length and the diameter of the canal and the normal contour of the femur may be made by obtaining a roentgenogram of the uninvolved femur with a nail of known length and diameter taped to the lateral surface of the skin, parallel to the femoral shaft. Another method of obtaining the approximate length is to measure from the knee joint to the greater trochanter and subtract 4 cm. The correct diameter can always be determined at operation by inserting

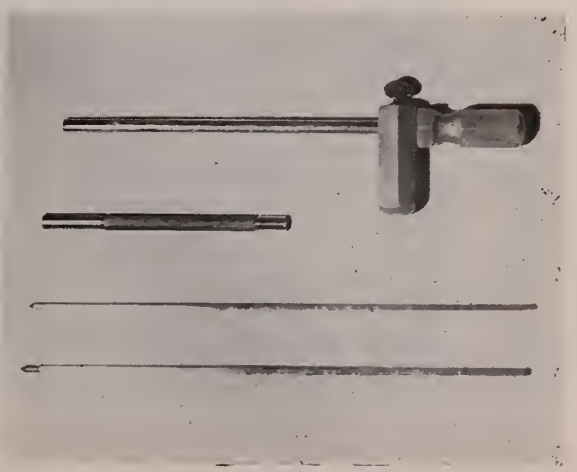
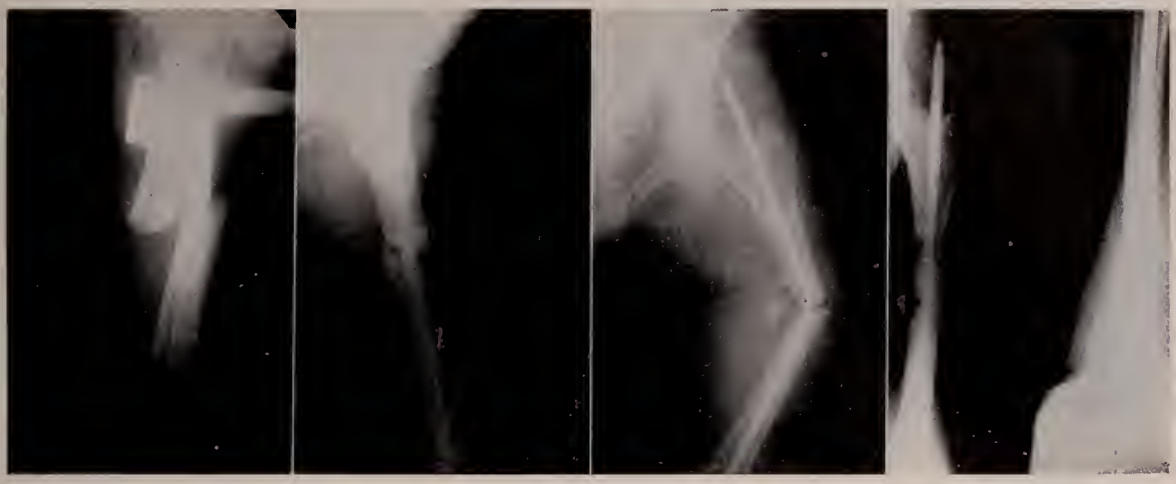


Fig. 1.—Top to bottom: driver and extractor, 9 mm. pin, and 11 mm. pin.

Table 1.—Analysis of Cases

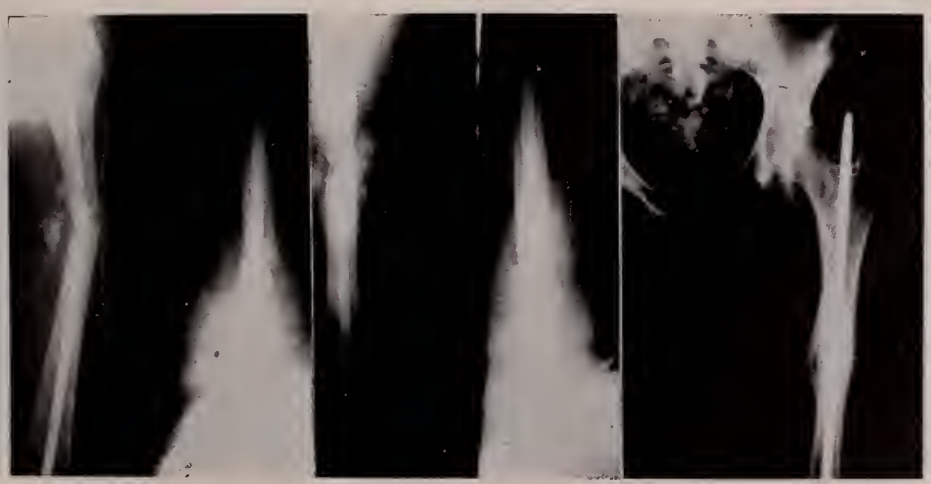
CASE	AGE	SEX	TYPE OF INJURY	LOCATION	ASSOCIATED CONDITIONS	HOSPITAL DAYS		POSTOPERATIVE DAYS BEFORE CRUTCHES	LIGHT DUTY	REGULAR DUTY	MOTION OF KNEE AND ANKLE	PIN REMOVED	HOSPITAL DAYS	COMPLICATIONS
						Before Surgery	After Surgery							
1	20	F	Comminuted fracture, left femur	Upper third of shaft	Cerebral concussion, mild	1	20	18	7 mos.	10 mos.	Complete	11 mos.	2	Bent pin twice, 2 mos and 5 mos. delayed union
2	47	F	Oblique, compound comminuted fracture, left femur	15 cm. distal to greater trochanter	Compound fracture, left forearm, maceration, face about nose	18	14	None, walked with aid in 6 wks.	2 mos.	4 mos.	Complete	5 mos.	2	5/8 in. shortening
3	17	F	Transverse fracture, left femur, simple, complete	Mid-shaft	Fracture, left proximal tibia, right foot	10	18	21	3 mos.	5 mos.	Complete	7 mos.	4	None
4	18	F	Fracture, right femur	Lower third	Severe contusion, right knee	15	10	60	5 mos.	7 mos.	Complete	6 mos.	8	20° rotation external; ½ in. shortening
5	35	M	Old fracture, left femur with severe angulation		Deformity, anterior bowing and 10 cm. shortening	3	27	25	5 mos.	6 mos.	Complete	Not removed to date	....	Delayed union
6	18	M	Comminuted fracture, right femur with 2 separate fragments	Mid-shaft	Fracture, distal fibula at left ankle	15	20	12	4 mos.	5 mos.	Complete	5½ mos.	2	None
7	11	M	Re-fracture, right femur	Mid-shaft transverse	Screws in previous fracture site	4	16	21	4 mos.	5 mos.	Complete	8 mos.	8	None
8	20	M	Compound fracture, right femur; fracture, left femur	Middle third	Fracture, right tibia	22	28	36	3½ mos.	.....	Right knee, 180°-60°; left knee, complete	Not removed 5 mos.	 1	5/8 in. shortening None
9	23	F	Fracture left femur	Union of middle and upper thirds	Laceration of face; shock, severe, 6 mos. pregnant	10	13	21	.....	.....	Complete	Not removed to date	....	None



COMMINUTED FRACTURE | AFTER REDUCTION | BENT PIN 2 MOS. AFTER FRACTURE | STRAIGHTENED PIN

Figure 2a, Case 1

a 9 mm. pin into the shaft of the femur, then estimating whether or not an 11 mm. pin would pass readily. The isthmus of the canal is the smallest point. For the insertion, the patient is placed on the uninvolved side with the thighs flexed about 40 degrees and the knees flexed 90 degrees. The incision can be made anterolateral or posterolateral. The posterolateral incision is usually the incision of choice for if a hematoma develops, it will frequently drain spontaneously and avoid the possibility of infection arising in this culture material. The anterolateral incision often does not require as much separation of muscle as would be expected, for the muscles are frequently torn about the fracture. Little periosteal elevation is necessary to expose and approximate the ends of the bone, this being another advantage over the plate method of femoral fixation. Minimal periosteal elevation leads to rapid healing because of unaltered circulation of the fragments.



REBENT PIN, 4 MOS. AFTER FRACTURE | NEW PIN WITH BONE GRAFT | HEALED, 9 MOS. AFTER FRACTURE

Figure 2b, Case 1

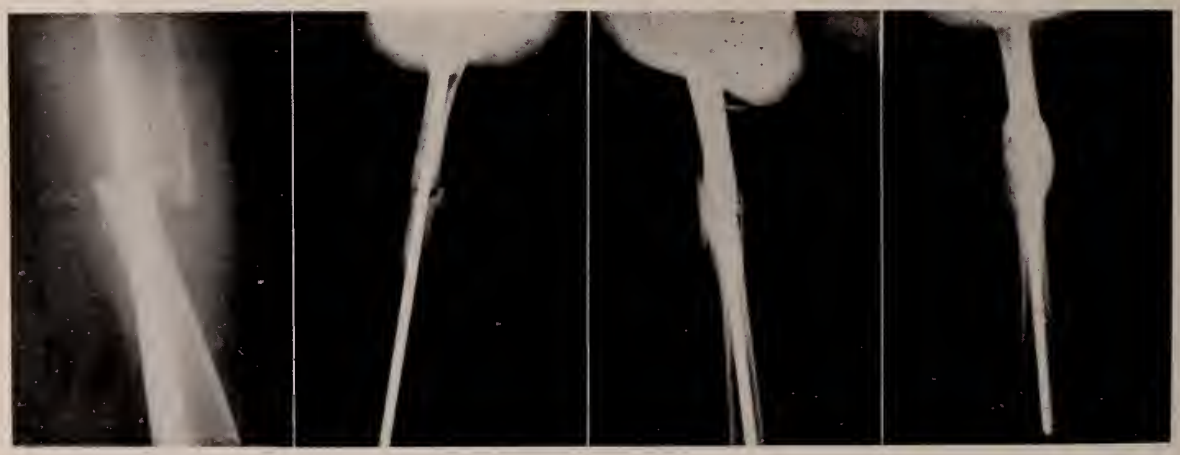


COMPOUND COMMINUTED FRACTURE

BONE GRAFT IN CALLUS

Figure 3, Case 2

The pin, which has been selected for the proper length and proper diameter is driven proximally, and it will readily be detected when the sharp end contacts and later breaks through the superior cortex of the trochanteric area. The pin will then protrude in the buttock, and a small incision allows it to extrude. The skin about the pin is covered, and the pin is driven proximally until the lower end is about ½ cm. below the distal end of the proximal fragment. The fragments are then approximated and aligned. The fragments can readily be held with a clamp while the pin is then driven distally. As the top of the pin approaches the greater trochanter, roentgenograms



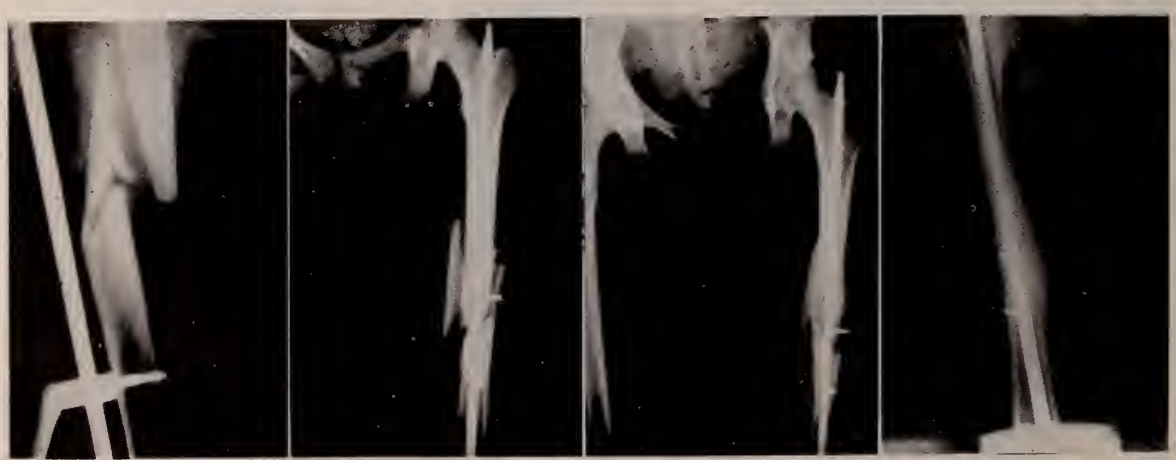
SIMPLE COMPLETE FRACTURE

NOTE BONE GRAFTS

NOTE BONE GRAFTS

7 MOS. POSTOPERATIVELY GRAFTS INCORPORATED

Figure 4, Case 3



SIMPLE COMMINUTED FRACTURE

BONE GRAFTS POSTOPERATIVELY

BONE GRAFTS INCORPORATED

BONE GRAFTS INCORPORATED

Figure 5, Case 4



40° ANTERIOR ANGULATION | 2 MOS. POSTOPERATIVELY | 6 MOS. POSTOPERATIVELY

Figure 6, Case 5

of the knees should be taken in two planes to evaluate the position of the pin in relation to the articular cortex.

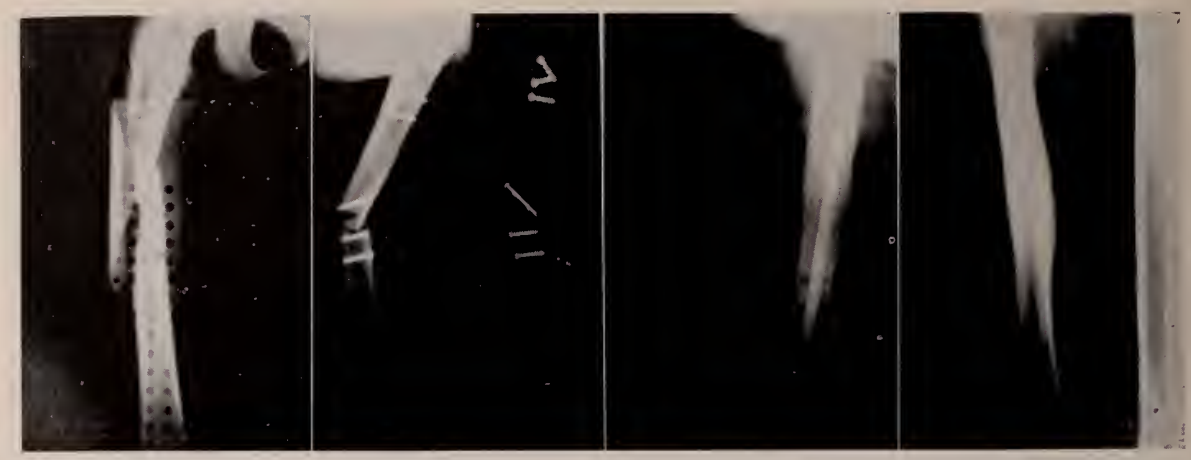
The pin should not protrude more than 1½ inches above the trochanter. This provision will avoid the pain in the buttock caused by irritation from the prominent sharp upper end. Caution should be used in the alignment of the fragments, for here is a possible chance of complication. If the fragments are angulated, the nail may penetrate the cortex, or, if rotation is not correct, it cannot be corrected later.

This type of fixation is of particular value in that it allows early activity of the muscles; thus motion of the joint is not impaired, and swelling is decreased. Blood flow is said to be twenty times greater in active muscles than in muscles during rest.[1] In only 1 of the cases presented was the knee joint limited in motion; in this extremity the femoral and tibial fractures were compound, and there was a large laceration at the knee which extended 4 or 5 inches along the femoral shaft. Much of the quadriceps muscle and tendon was lacerated above the knee. Even in this case, at six



SIMPLE COMMINUTED FRACTURE | 6 WKS. POSTOPERATIVELY | 6 MOS. POSTOPERATIVELY

Figure 7, Case 6



OBLIQUE COMMINUTED FRACTURE | REFRACTURE AFTER 7 MOS. | BONE GRAFTS POSTOPERATIVELY | PIN OUT, 8 MOS. POSTOPERATIVELY

Figure 8, Case 7

months the knee motion was 80 per cent of normal.

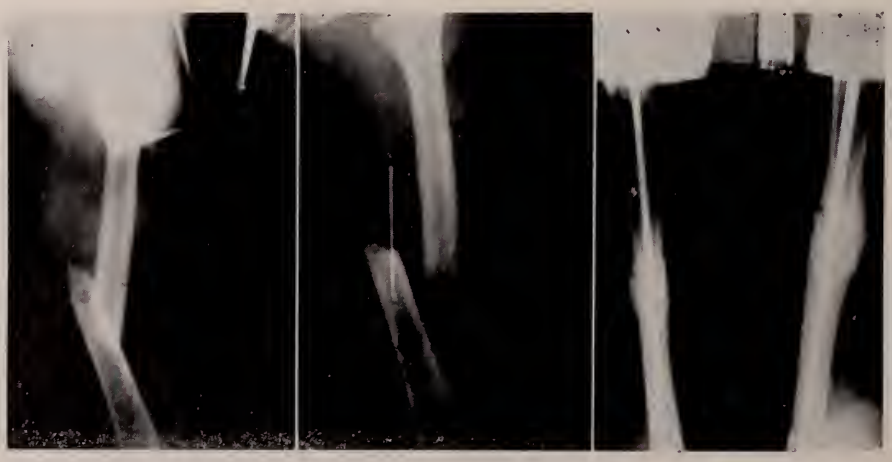
The normal motion greatly decreases disability as compared with other methods of treating these fractures. Early ambulation is of added advantage, but great care should be taken to avoid false security. As shown in case 1, the intramedullary pin will not support weight, and weight-bearing cannot be permitted until sufficient callus is present. The pin may not bend, but such possibility is present until the callus is sufficient to bear weight. It is considered wise to prolong the use of crutches and encourage the patient to walk with a stiff knee until abundant callus is present.

Bone grafting at the time of fracture fixation is popular with some surgeons.[2] This is one way to help prevent such complications as occurred in case 1 (bent pin), for abundant callus will develop rapidly when small pieces of homogenous or bone bank bone are placed adjacent to the fracture site.

Analysis of the 9 cases of this series can be quickly made by reference to table 1 and figures 2 to 10.

Conclusion

Intramedullary pin fixation in femoral fractures permits early motion, decreases hospital stay and nursing care, and overcomes the depressing



LEFT TRANSVERSE FRACTURE | RIGHT TRANSVERSE FRACTURE | BILATERAL VIEW HEALED IN 5 MOS.

Figure 9, Case 8



SIMPLE TRANSVERSE FRACTURE

NOTE GRAFT AND ABUNDANT CALLUS AT 6 WKS.

Figure 10, Case 9

confinement of a hip spica cast. Mention has been made of the complications, such as bent pin, and shortening and rotation of fragments, to help others avoid these pitfalls. Bone grafts aid in producing extracortical callus, thus allowing earlier motion and weight-bearing. Bone obtained from a bone bank shortens operative time, minimizes surgical shock, decreases postoperative pain and lessens convalescent time.

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1206 North Palafox Street.

Diseases of the Parotid Gland

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The name parotid is derived from two Greek words meaning near and ear. Galen applied the name to an abscess of the ear. The function of the parotid gland and duct was described by Stensen in 1662.[1]

Embryology

The parotid glands are the first of the salivary glands to make their appearance. They become manifest during the sixth week by an ingrowth of oral epithelium into the underlying mesenchyme on the inner surface of either cheek and are believed to be derived from stomodeal ectoderm.

The ingrowth of epithelium is rapid and toward the ear. The main duct branches into primordial cell cords which form the parenchymatous part of the gland, consisting of the branch ducts and the terminal alveoli. The surrounding mesenchyme forms the connective tissue framework of the gland, which establishes septums dividing the gland into lobules.[2] Developing lateral to the main branch of the facial nerve, the gland so envelops this nerve that it is eventually surrounded by glandular tissue. The parotid gland is entirely an albuminous gland in that it secretes only serous watery liquid and no mucus.

Anatomy

This gland has a large superficial lobe connected by an isthmus to a smaller deep portion. This bilobate gland is bounded in part by the ramus of the mandible, which is covered by the masseter and internal pterygoid muscles. The posterior boundaries consist of the external auditory meatus, the tympanic plate and the base of the styloid process. Here it lies in close relationship to the posterior belly of the digastric, the stylohyoid and the sternocleidomastoid muscles laterally and the styloglossus and stylopharyngeus muscles medially. Anterior to the styloid process, the medial surface of the gland forms the lateral boundary of the lateral pharyngeal space. This relationship is one of clinical importance to the otolaryngologist.

The largest expanse of the gland is superficial where it is covered by the parotidomasseteric fascia, which is a continuation of the superficial layer

Read before the Florida Society of Ophthalmology and Otolaryngology, Twelfth Annual Meeting, Hollywood, April 22, 1951.

of the deep cervical fascia. Closely adherent to the glandular substance, this fascia forms partitions which pass through the gland, making its dissection difficult. The superficial portion of the gland may extend up to the zygoma, over the masseter muscle and inferiorly to the stylomandibular ligament, which separates it from the submaxillary gland. A prolongation over the masseter muscle, which may be nearly distinct from the remainder of the gland, is known as the accessory parotid gland. Emerging from the front of the gland, the parotid duct traverses the masseter muscle and turns inward at its anterior border to pass through the buccinator muscle and oral mucous membrane opposite the second molar tooth.

The facial nerve leaves the temporal bone at the stylomastoid foramen medial to the mastoid and lateral to the styloid processes. It continues in an anteroinferior and lateral course to enter the parotid gland posteriorly. Soon after entering the gland, it usually divides into its two major trunks, the temporofacial and the cervicofacial. This division as a rule occurs in the region of the isthmus. The temporofacial trunk ascends above the isthmus, spreading out in the gland to form the temporal, zygomatic and buccal branches. Descending beneath the isthmus, the cervicofacial trunk divides in the gland, forming the mandibular and cervical divisions. The cervicofacial and temporofacial trunks arborize in variable patterns distal to the isthmus, and anastomoses have been demonstrated between these distal divisions.

Nerve Supply of the Parotid Gland

The craniosacral and thoracolumbar divisions of the autonomic nervous system supply the parotid gland with secretory nerves. The craniosacral fibers arise in the medulla from the inferior salivatory nucleus situated at the upper end of the nucleus of the glossopharyngeal nerve. These fibers travel with the glossopharyngeal nerve to the jugular foramen, where they separate from it in its tympanic branch. They leave the tympanic plexus in the trunk of the small superficial petrosal nerve which conveys them to the otic ganglion, where they communicate with ganglion cells from which postganglionic fibers arise. The auriculotemporal branch of the fifth cranial nerve transmits these postganglionic fibers to the cell of the gland.

The cell stations for the thoracolumbar fibers lie in the superior cervical ganglion. The preganglionic fibers arise from the upper one or two thoracic segments. The postganglionic fibers reach the gland by way of the plexuses of the external and internal carotid arteries.

The dilator fibers for the blood vessels travel with the craniosacral fibers and the constrictor fibers with the thoracolumbar fibers.

Allergic Parotitis

Failure to recognize a clinical entity which has long existed perhaps accounts for the dearth, until recently, of literature pertaining to allergic involvement of the salivary glands. Hansel[3] believed that, in many cases, the disease referred to as chronic recurrent parotitis is actually allergic in nature.

Allergy of the parotid gland is usually associated with other allergic manifestations, such as generalized urticaria, nasal obstruction with watery rhinorrhea, sneezing, asthma, lacrimation and headache. The painful swelling of one or both parotid glands may recur for variable periods of time. Zinder and Fraser[4] reported a case of allergic parotitis caused by exposure to turkey feathers and the ingestion of turkey meat and other specific foods, with complete relief obtained by elimination of the specific foods and the use of inhalant therapy. In the opinion of Waldbott and Shea,[5] the swelling may be due to an allergic edema of the ducts or glandular tissue, or to a blockage of the ducts by plugs of mucus similar to those present in the bronchi in bronchial asthma.

Ruling out other diseases, such as stone in the duct, and a history of allergy usually establish the diagnosis. Eosinophils are generally found in a smear made from the parotid secretion. Purulent secretion may be seen coming from the duct, owing to secondary infection superimposed on a dilation of the duct system caused by an allergic parotitis.

Treatment consists of the recognition of, avoidance of, and desensitization to the offending allergens.

Acute Inflammation of the Parotid Gland

With the advent of chemotherapy, antibiotics, and the judicious management of fluid balance, the incidence of acute suppurative parotitis and its complications has markedly decreased.

Furstenberg[6] was of the opinion that the long-recognized relationship between parotid abscess and major abdominal and pelvic operations is due to dehydration in the surgical patient for he had not observed the development of such an abscess in a patient in whom the fluid balance was adequately maintained. Lacking a protective flow of saliva, the dehydrated parotid gland may be sub-

ject to infection by a retrograde extension of bacteria from the mouth. This author believed the parotid gland may be injured by the anesthetist in forcibly placing his fingers over the mandible to hold the jaw forward during anesthesia. Such injury might make the gland less resistant to infection. The present use of the endotrachial tube for prolonged anesthesia minimizes this possibility.

Acute suppurative parotitis occurs in the newborn, 30 to 40 per cent of the cases occurring in premature infants.[7] Injury at birth, poor oral hygiene, puerperal disease in the mother, and cracked or diseased nipples are probable causes.

Recurrent bouts may result from calculi in the gland or in Stensen's duct. The hematogenous or lymphogenous spread from distant or adjacent structures is an etiologic factor. When associated with debilitating disease, the parotitis is usually caused by dehydration and poor oral hygiene. Suppuration in the lateral pharyngeal space may spread by direct continuity to the medial aspect of the parotid gland.

Massive doses of antibiotics and chemotherapy should be instituted at once. The agent of choice depends upon the organism isolated. Sound principles of body fluid balance, as described by Coller and Maddock,[8] should be followed. Adequate hydration re-establishes salivation and allows the gland to clear itself of bacteria, thus preventing further retrograde extension. Good oral hygiene is essential.

Roentgen therapy in doses of 100 r is given every two days for four doses. Calculi should be removed by incising the duct. When suppuration occurs, Furstenberg[6] advocated wide incision and drainage of the parotid gland. Beginning at the level of the zygoma, the incision extends down in front of the ear beneath the angle of the mandible and forward for 2 to 3 cm. The skin and subcutaneous tissues are reflected forward, and several incisions are made horizontally into the substance of the gland to provide massive drainage.

Xerostomia

True xerostomia, or dry mouth, is a relatively rare condition of obscure etiology. The patient complains of excessive dryness of the lips and mouth and of diffculty in swallowing and chewing because of the lack of saliva. When saliva is present, it is usually thick and mucoid in nature.

The mucous membranes are parched, and pressure over the salivary glands and their ducts expels little saliva. The tongue is rough and fissured; dried crusts may be present on the surface. The pharynx and hypopharynx are usually especially dry and crusted.

Xerostomia is not to be confused with the complaint of dry mouth unsubstantiated by objective findings. The patient with the latter complaint generally manifests other functional complaints and frequently complains of a burning tongue. As a rule, he has resorted to numerous vitamins, mouth washes and multiple forms of therapy without noted improvement. This type of patient should be directed to a psychiatrist rather than to the corner drugstore for further vitamin therapy.

Disease of only one or two of the salivary glands does not result in symptoms of impaired salivation.

Numerous etiologic factors have been suggested. Greenbaum and Tumen[9] reported a case following roentgen therapy for hypertrichosis. In this type of case the pathologic change is probably due to atrophy and scar tissue replacement of the glandular tissue. Congenital xerostomia may occur through an absence or underdevelopment of the salivary glands. A familial tendency has been demonstrated for this disease.[10] If sufficient salivary tissue is destroyed in such diseases as Mikulicz's disease, sarcoidosis and lymphoblastoma, dry mouth may result.[10] Furstenberg and Crosby[11] mentioned the causal effect of exposure to organic dust and zinc poisoning. It has been demonstrated that psychiatric disorders may depress salivary activity. Saphir[12] successfully treated a case of xerostomia with nicotinic acid and suggested that nicotinic acid deficiency should be included among the etiologic factors.

Noting the relationship between dryness of the mouth and dryness of the eyes (keratoconjunctivitis sicca), Allington[10] stated that there also may be an associated dryness of the nose, throat and vagina and a deficient gastric secretion. Frequently, rheumatoid arthritis is an associated condition. This author designated this set of symptoms as Sjögren's syndrome, naming it for the Swedish ophthalmologist, Henrick Sjögren, who first described the relationship in 1933. Most frequently this syndrome occurs in women in the postmenopausal period. Allington[10] was of the opinion that hormonal insufficiency may be etiologically important. He noted similarity between this syndrome and the changes occurring in Plummer-Vinson syndrome, pernicious anemia, iron deficiency anemia, and deficiency of vitamin A, nicotinic acid and riboflavin.

It was the conclusion of Furstenberg and Crosby[11] that the pathologic change responsible for xerostomia is usually not demonstrated. They regarded the onset of salivation after the administration of pilocarpine as proof of some disorder in the secretory fibers since pilocarpine has a predilection for the end organs of the secretory nerves.

The treatment of xerostomia has been, in general, rather unsatisfactory. Furstenberg and Crosby[11] advocated the oral use, for three to six weeks, of pilocarpine hydrochloride or pilocarpine nitrate in 10 mg. doses three times a day before meals. The patient should be left in a mild state of acidosis by restricting alkalies and administering 3 Gm. of ammonium chloride with meals three days on and two days off during the uninterrupted administration of the pilocarpine. Acetylcholine, which initiates the nerve impulse of the secreting fibers, is less rapidly broken down by cholinesterase in an acid medium. In selected cases, hormonal therapy, vitamin therapy and psychotherapy should be instituted.

Case 1. — R. T. L., a white male accountant aged 43, complained of a consistently dry mouth, difficulty in swallowing and chewing food, inability to chew gum because of the lack of saliva, and almost no perspiration on exertion. He had acquired dryness of the mouth and lips while serving with the armed forces in Central America seven years prior to consulting me. For ten months, he had been on a deficiency diet consisting of meat and potatoes with fruits and vegetables lacking.

The results of physical examination were normal except for a dryness of the mouth, pharynx, nasopharynx, larynx and nasal mucous membrance. There was also diminished lacrimation. Pressure over Stensen's duct failed to express any saliva, but pressure over Wharton's duct yielded a thick mucoid saliva.

The patient received 10 mg. of pilocarpine hydrochloride three times daily one-half hour before meals continuously and ammonium chloride 3 Gm. three times daily with meals three days on and two days off for a period of three weeks. For approximately an hour following administration of the pilocarpine, he noted an increase in saliva to an extent greater than at any time during the preceding seven years. Perspiration was profuse during the period of increased output of saliva. There was no improvement in the flow of saliva after the pilocarpine was discontinued. He then received vitamin therapy for two months with no appreciable change in symptoms.

Ptyalism

The opposite of xerostomia, ptyalism is an excessive secretion by the salivary glands. It may be due to excessive central excitation[13] or to reflexes excited by irritating lesions in the mouth or esophagus. It occurs commonly in carcinoma of the mouth, pharynx, larynx and esophagus. It may be functional in nature.

Atropine is the treatment of choice. The irritating lesions should be removed if possible. Sectioning of the auriculotemporal nerve has been advocated in resistant cases.

Fistulas

The commonest cause of fistula of the parotid gland is traumatic laceration of Stensen's duct. Inadvertently, the duct may be entered during surgical procedures in the vicinity. Fistula of the gland substance occurs less frequently and is less troublesome. Rarely, fistula follows a wide dissection of the gland in repair of the facial nerve and removal of parotid tumors in a noninfected field. It occurs more frequently after incision of a parotid abscess, and may occur with acute and chronic infections and ulcerating neoplasms.

Glandular fistulas involving small tributaries of the ductal system often close spontaneously owing to the formation of scar tissue with occlusion of the involved duct. This process may be hastened by local pressure, chemical or electrical cautery, or roentgen therapy. In dealing with more extensive fistulas, as those observed in ulceration of the gland, some advocate avulsion of the auriculotemporal nerve. This deprives the gland of its secretory fibers through the craniosacral nerve supply. The nerve runs parallel and posterior to the vertical portion of the temporal artery. The portion of the nerve central to the gland is avulsed.[14]

Treatment of fistula of Stensen's duct presents a more formidable problem. It is estimated that one parotid gland secretes approximately 500 cc. of saliva daily.[15] The diversion of this stream from a well formed fistula to a reconstructed duct is technically difficult.

In 1945, Wallace[16] reported the successful primary repair of a lacerated duct and described the procedure. A year later, Newman and Seabrook[17] reported that during World War II they successfully closed 5 salivary fistulas of variable duration by surgical repair of the duct. They presented their technic in detail.

Some roentgenologists consider roentgen therapy the treatment of choice for parotid fistulas. The rationale for this therapy is the temporary suppression of the salivary flow in order to give the fistula a better chance to close spontaneously. Popma[18] advised immediate roentgen therapy for traumatic injuries of the parotid gland to prevent fistula formation. Administering 400 r on two succeeding days, Portmann[15] used 800 r as measured on the skin over the parotid gland in 3 cases with gratifying results. He observed that the function of the gland may be resumed in four months and that meanwhile the fistula will usually have closed. He advocated roentgen therapy first for all

parotid fistulas, and if it fails, then operative repair may be attempted.

Sialolithiasis

Calculi occur rarely in the parotid gland or duct. The causative factor is believed to be the precipitation of the salts of calcium, magnesium, sodium and potassium, or a minute foreign body, or precipitated mucin in the duct. In a review of 110 cases of sialolithiasis, New and Harper[19] reported the relative incidence in the salivary glands and their ducts as submaxillary 92.9 per cent, parotid 4.3 per cent, and sublingual 2.8 per cent.

Usually intermittent in character at the onset, swelling is accompanied by severe pain in the region of the gland or duct and is worse during meals. Both often subside in a few hours. With increased obstruction secondary infection occurs, followed by continuous pain, swelling, and tenderness of the gland. Purulent secretions may be expressed from the orifice of the duct, and the gland manifests classical symptoms of inflammation. If the stone is not removed, suppurative parotitis may ensue.

In most cases, the stone can be palpated with a probe in the duct and can be demonstrated roentgenologically. A calculus in Stensen's duct is removed under local anesthesia by inserting a probe in the duct and incising the duct along the probe to the stone, which is then removed. The incised duct is not sutured and heals well in several days. Small calculi, however, may remain in the duct for long periods of time, causing fibrotic changes resulting in stenosis with symptoms of recurrent obstruction.

Case 2. — G. M., a white man aged 29, first consulted me on June 22, 1950, complaining of intermittent swelling and pain over the left parotid gland and a lump in the left cheek. The onset of these symptoms occurred in 1945 while he was serving in the Navy. At that time the region over the left parotid gland was painful, red and swollen, increasingly so during meals. The swelling subsided after he had received penicillin for one week. During the five year interval, he had been conscious of a painful lump in the cheek, but had experienced no further episodes of swelling in the parotid region. For several months prior to consulting me, he had noted increased swelling of the left parotid gland during meals. Drinking alcoholic beverages increased the swelling and caused severe pain.

Physical examination gave negative results, except for the left parotid duct. Saliva containing stringy mucin could be expressed from the orifice. Palpation anterior to the left masseter muscle revealed a firm tender mass approximately 1 by 2 cm. in diameter. A probe in the duct could not be passed beyond this mass. No stone was palpable, but roentgen examination gave evidence of a small stone in the duct.

On July 11, with the patient under endotracheal nitrous oxide ether anesthesia, a probe was inserted to the point of obstruction, and the duct was incised. Two stones, one approximately 3 mm. and the other 7 mm. in greatest diameter, were removed. Proximal to the stones, there was palpated a fibrous tissue mass through which a probe could not be passed. The mass was excised by sharp dissection. The duct proximal to this area appeared dilated. Normal-appearing saliva was expressed. The edges were sutured to the buccal mucosa with 4 small dermalon sutures.

The microscopic description of the specimen follows: "Four sections through the salivary duct show an extremely dense fibrocollagenous type of tissue surrounding a small epithelial-lined duct, the cells of which appear to be essentially normal. A large number of extremely thick-walled vascular channels are seen in the dense fibrocollagenous tissue surrounding the epithelial-lined channels. Here, also, are large numbers of chronic inflammatory cells and spotty areas of calcification. No definite evidence of neoplasia is noted." The pathologic diagnoses were: "(1) Fibrosis and hyalinization in periductal tissue. (2) Chronic inflammation and calcification in periductal tissue."

The patient received procaine penicillin, 400,000 units daily for four days. He was discharged from the hospital on the third postoperative day, the stitches were removed on the seventh postoperative day, and recovery was uneventful.

On March 8, 1951, he stated he had had no more pain or swelling of the left parotid region. There was a free flow of saliva from Stensen's duct. The sphincteric function of the duct was absent. Slight pressure over this area resulted in a copious flow of saliva, while firm pressure over the parotid region on the right side expressed only a scant amount. Instead of the usual pin-point opening of the papilla, there was a vertical slit. The loss of the papilla may make the duct and gland more susceptible to infection from the contents of the mouth. Newman and Seabrook[17] stressed the importance of preserving the sphincteric and valvular action of the papilla when possible. As yet, the patient has experienced no ill effects as a result of this loss.

Solitary or multiple stones may occur in the gland proper. They may be removed by reflecting the skin and subcutaneous tissues over the gland, palpating the stones and excising them from the parenchyma of the gland.

Parotid Tumors

The differential diagnosis of parotid tumors must include tumefactions resulting from inflammatory lesions, tumors of connective, vascular and nervous origin, and neoplasms arising from the parenchyma of the gland itself.[20]

Chronic recurrent parotitis may produce a firm nodule in the gland simulating a tumor. Howard and his associates[20] preferred biopsy to resection as no serious sequelae have been reported from this condition. Parotidectomy for this type of lesion has resulted in facial paralysis.

Parotid cysts may result from atresia of the ducts secondary to previous inflammatory changes. These should be excised.

Hemangioma and hemangioendothelioma usually occur during the first year of life. As a rule, these tumors are benign and are treated either by irradiation or a combination of irradiation and surgery. The cavernous type of hemangioma may be lethal because of its rapid extension and resistance to roentgen therapy.

Neurofibroma, lipoma and sarcoma occur rarely in the parotid gland. They should be removed surgically.

Papillary cyst adenoma lymphomatosum, also known as adenolymphoma or Wharthin's tumor, is composed of papillary epithelial projections in a lymphoid stroma. The origin is uncertain, but it is thought to be due to an embryonal rest from the first bronchial cleft. It is a benign lesion, occasionally bilateral, occurring mostly in males. The treatment is surgical excision. The tumor rarely recurs if completely excised.

The majority of parotid tumors are classified as mixed tumors of the salivary glands. The literature contains much theorizing as to their etiology. These tumors contain epithelial cells which often assume a glandular architecture, surrounded by myxomatous material which stains like cartilage. Scattered through this matrix are connective tissue and occasionally lymphoid tissue and bone. These tumors do not imitate the normal structures of salivary glands and may be found at distant sites, such as the tongue, nasopharynx, hard palate and nasal accessory sinuses. It is generally accepted that these tumors are derived from rests of embryonal ectoderm owing to some disturbance in embryonic development.

Tumors of this type usually occur between the second and fourth decades. The onset is as a rule marked by a painless mass in front or behind the mandible. The flow of saliva is normal, and it is usually clear. There is a gradual increase in the size of the tumor, and its presence may be unknown to the patient until a period of rapid growth occurs. A firm well defined mass is palpable in the superficial portion of the gland. It is less well defined in the deep portion. Benign mixed tumors do not cause a facial paralysis. These tumors may increase gradually in size for ten to twenty years and then increase rapidly. The patient usually does not seek surgical relief for an average of seven years.[6] In negligent patients, these tumors may obtain enormous size. Those located in the inner prolongation of the gland may extend through the lateral pharyngeal space and displace the tonsil and palate medially.

A wide discrepancy of opinion as to treatment exists in the literature. Some authors advocated deferring surgery until the patient has discomfort or there is a suspected or known malignancy of the tumor.[21] McFarland[22] advised the postponement of an operation until the tumor is "ripe," or about the size of a lemon. Others advocated surgical removal as soon as a tumor of this type is discovered.[23,24]

Buxton, Maxwell and Cooper[23] believed this discrepancy of opinion is due to a pessimistic attitude which has prevailed in the past. A lack of exact knowledge of the anatomy of the facial nerve and its branches has made the surgeon hesitant in the removal of the mixed tumors for fear of a postoperative facial paralysis. The belief that these tumors recur and with each recurrence there are increased cellularity and potential malignant change has long been accepted. Further pessimism has been manifested in the belief that if the tumor is carcinoma, excision fails to offer much benefit. These authors in reviewing a series of 227 cases of primary tumor of the parotid gland, of which 113 were benign mixed tumors, found only 3 cases in which there was a definite change from a benign to a malignant lesion in a mixed tumor following the initial excision. In these 3 cases there was an interval of ten to twenty years between the initial excision and recurrence. They concluded that time rather than surgical trauma is the important factor in the development of malignant change in a benign mixed tumor.

The average recurrent rate in the literature has been approximately 25 per cent.[25] McFarland[22] observed that the smaller tumors recur about twice as fast as the larger ones. He believed that smaller tumors are more apt to have small undiscovered outlying lobules that are left behind during operation. The onset of the recurrence may occur up to twenty or thirty years after excision of the original tumor. Several reasons for the high recurrence rate have been given. The inadequate excision of small tumors under local anesthesia probably accounts for the high recurrence rate in small tumors.[23] The tumors may be of multicentric origin, having other foci in the gland substance. Small satellite tumor cells may exist outside of the capsule. Klopp and Winship[26] demonstrated "seeding" of the gland following removal of these tumors with recurrence at the involved sites. They also demonstrated tumor cells in the capsule of a mixed tumor and they believed that enucleation of the tumor does not adequately remove all tumor cells.

Stein and Geschickter[27] reported a recurrence rate of 50 per cent following enucleation of a mixed tumor as compared with that of 13 per cent following excision of the tumor with a margin of parotid tissue. Klopp and Winship[26] advocated subtotal parotidectomy with almost complete removal of the parotid gland to prevent recurrence of mixed tumors. Brown, McDowell and Fryer[28] reported successful removal of 75 mixed tumors

with no paralysis of the facial nerve and no recurrence over a period of ten years. They advocated a wide exposure of the gland and removal of the tumor with the capsule intact. Irrigation of the wound with copious quantities of saline is carried out to remove any contamination with tumor cells. Buxton, Maxwell and Cooper[23] reported a recurrence rate of mixed tumors of 10.9 per cent in a group of 113 patients, for 57 of whom the postoperative interval was less than five years. They advocated visualization of adjacent branches of the facial nerve and resection of the intact tumor with a wide margin of adjacent parotid gland.

The technic employed by Buxton, Maxwell and Cooper[23] in the removal of parotid tumors and in exposing the main trunk of the facial nerve and its branches when dealing with these tumors follows: The incision begins just below the zygoma and immediately in front of the tragus, extending vertically to 1 to 2 cm. beneath the lobule of the ear and posterior to the angle of the mandible, where it is curved forward along the posterior belly of the digastric muscle. The skin and subcutaneous tissues of the flap are reflected forward, exposing widely the surface of the parotid gland. Normal glandular tissue usually has to be incised to expose the capsule of the tumor. Prior to incision of the glandular tissue, the electrode of a faradic stimulator is passed over the tissue to be incised. If no facial movements are incited with 2 to 3 volts, one may reasonably assume that incision into the glandular tissue is safe. Maxwell devised an excellent stimulator for use in cases of this type and for work involving the facial nerve in the temporal bone.

Tumors arising in the deep portion of the gland may produce atrophy of the superficial glandular tissue and displace the facial nerve far from its normal course. The tumor, its capsule and a margin of normal parotid tissue should be removed without rupturing the capsule. Tumors in the superficial portion of the gland may rest on branches of the facial nerve. One must be careful in dissecting the mesial portion of the tumor to avoid injuring the nerve.

When tumors lie in the deep portion of the gland, the nerve may be displaced upwards, inferiorly or laterally. Buxton and his associates[23] advised isolating the facial nerve prior to dissection of the tumor. They advocated several different methods for exposure of the nerve. When the tumor is large and encroaches upon the stylomastoid foramen, the zygomatic branch of the nerve which lies inferior and parallel to the zygomatic process may be isolated and traced posteriorly to the main trunk of the nerve. A similar method is to isolate the mandibular branch beneath the ramus of the mandible and trace it posteriorly. The mastoid tip may be removed and the nerve isolated at the stylomastoid foramen and traced forward. The method most frequently used by these authors was devised by Maxwell. The posterior aspect of the gland is separated by sharp and blunt dissection from the perichondrium of the external auditory canal down along the tympanic plate of the petrous bone to the base of the styloid process. The main trunk of the facial nerve is identified as it passes first lateral to the base of the styloid process and is then traced anteriorly to the pes anserinus. The faradic stimulator is of great value in all of these technics.

Some advocate the use of roentgen therapy in conjunction with surgical removal of parotid tumors. The epithelial elements of the mixed tumors are thought to be sensitive to roentgen rays even though the myxomatous tissue is insensitive. The capsule is believed to be thickened by roentgen therapy, thus facilitating removal. Buxton and his associates[23] did not recommend roentgen therapy in the treatment of mixed tumors because there is little evidence that complete destruction of a mixed tumor is obtained without extensive damage to normal structures.

Carcinoma

Carcinoma of the parotid gland is usually divided into two groups, the lesions arising in mixed tumors and those primary in the gland, generally of ductal origin. The latter group includes pseudoadenomatous basal cell carcinoma, squamous cell carcinoma, adenocarcinoma and the mucoepidermoid types of carcinoma. Sarcoma of the parotid gland is rare.

Buxton and his associates[23] concluded that the occurrence of pain or tenderness over the tumor is of little value in differentiating malignant lesions. A rapid change in rate of growth is not always diagnostic of a malignant change as this also occurs in benign tumors. Paralysis of branches of the facial nerve associated with a tumor of the parotid gland is usually diagnostic of an infiltration of the nerve by a malignant tumor. Fixation of the tumor to the skin in the absence of previous surgery or roentgen therapy is usually diagnostic of a malignant tumor. In the early stages of a malignant tumor it is not possible to differentiate it from a

benign lesion. The average duration of symptoms in a series of 18 cases of malignant tumor reported by Jones, Scarborough and Brown[29] was five years.

Since it is not possible to make an early diagnosis of malignant tumors of the parotid gland, it follows that the best therapy for these tumors is adequate excision as soon as a tumor mass is diagnosed, provided an inflammatory process has been ruled out. If the neoplasm has broken through its capsule, the entire gland should be removed, with sacrifice of the fibers of the facial nerve which are infiltrated with the neoplasm. If the fibers are not involved, they may be spared by careful dissection.

Buxton and his associates[23] did not advocate postoperative irradiation in well encapsulated mixed tumors which show malignant change if they have been completely removed with a surrounding layer of normal gland. If complete removal of a malignant tumor is uncertain, roentgen therapy is administered to the limit of tolerance of the normal tissues.

Miscellaneous Diseases

Mumps (Epidemic Parotitis). — Mumps is an acute communicable virus disease. It usually occurs in childhood and is characterized by painful enlargement of the salivary glands. One or both parotid glands are swollen. The submaxillary glands and less frequently the sublingual glands may also be swollen. The prodromal symptoms of fever, anorexia, headache, vomiting and generalized aches and pains suggest a generalized infection. The enlargement of the salivary glands is probably a local manifestation of the disease. Permanent immunity usually follows the disease. Numerous subclinical cases probably occur which also give a lasting immunity.

Epididymo-orchitis and meningoencephalitis are the commonest complications. Nerve deafness, usually unilateral, may result from mumps, probably due to a selectivity of the eighth nerve by the virus. Laryngeal edema and pitting edema over the sternum may occur because of pressure on the lymphatics of the neck.

Tuberculosis. — Tuberculosis of the parotid gland is rare. The gland may be invaded by ascending infection through the duct or by lymphogenous or hematogenous spread. There may be a localized or diffuse swelling of the gland. Diagnosis is usually made by biopsy. Hersh[30] reported a case successfully treated with 1 Gm. of streptomycin daily for six weeks.

Uveoparotitis (Heerfordt's Disease). — Uveoparotid fever is a rare disease which usually occurs in young persons. It is characterized by fever, bilateral uveitis, parotitis and palsy of certain cranial nerves, most frequently the seventh. The disease is chronic, but as a rule terminates in recovery although with considerable loss of vision. Because it is occasionally coexistent with and similar pathologically to Boeck's sarcoid, it is considered by some to be another form of sarcoidosis.[31] Treatment is nonspecific.

Mikulicz's Disease. — Of unknown etiology, Mikulicz's disease is characterized by symmetric swelling of the lacrimal, orbital and salivary glands. Microscopically, there is a massive lymphocytic infiltration of the glandular tissue with a few eosinophils, plasma cells and, occasionally, giant cells.[32] Mikulicz's syndrome appears similar clinically, but is a local manifestation of a systemic disease, such as leukemia, tuberculosis, lymphosarcoma, syphilis, toxic reaction or gout. Roentgen therapy is the treatment of choice in Mikulicz's disease.[33]

Auriculotemporal Syndrome. — The auriculotemporal syndrome is a comparatively rare condition of the parotid gland manifested by redness and sweating over the temporal and periauricular area, and usually occurs in connection with eating. Pain and sensory disturbances in the form of increased or diminished sensation in the distribution of the auriculotemporal nerve are commonly present. The changes are elicited by tasting and not by chewing. It has been noted that spicy food stimulates the greatest response. Needles[34] stated that this condition occurs most commonly as a sequel to parotitis complicating an infectious disease. In several cases reported in the literature, this syndrome has followed traumatic lesions in the region of the parotid gland. It has occurred following excision of tumors of this gland.

The auriculotemporal nerve delivers both sympathetic and parasympathetic fibers to the parotid gland. Several theories have been presented regarding the etiology of the auriculotemporal syndrome. Some authors concluded that it is an exaggeration of a normally present reflex. Others believed that following injury to the auriculotemporal nerve there is a regeneration of nerve fibers and during this process some of the parasympathetic and sympathetic fibers intended for the parotid gland either grow out into the sweat glands of the skin or anastomose with fibers supplying the sweat glands.

In the opinion of Needles[34] the most likely explanation is that this anomaly arises from the formation of scar tissue resulting from injury in diseases of the parotid gland. When the gland is stimulated into activity, it swells, and pressure is then exerted on the vegetative fibers, which in turn results in vasodilatation and sweating. This author suggested the use of roentgen therapy in the treatment of this entity so that inhibition of parotid activity would relieve the pressure on the nerve fibers.

Summary

The salient features of diseases of the parotid gland are presented, and their treatment is discussed. These various diseases include allergic parotitis, acute inflammation, xerostomia, ptyalism, fistulas, sialolithiasis, parotid tumors, carcinoma and such miscellaneous diseases as mumps, tuberculosis, uveoparotitis, Mikulicz's disease and the auriculotemporal syndrome. The embryology, anatomy and nerve supply of the gland are also briefly reviewed.

Two cases are reported, one of xerostomia and the other of sialolithiasis.

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111 West Adams Street.

Proceedings of Seventy-Eighth Annual Meeting

Scheduled for Publication

in the June Issue

VOLUME XXXVIII
NUMBER 11

"Periarteritis Nodosa" with Encephalitic Lesions in a Child of Eighteen Months

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We were unable to find a case similar to the one reported in the literature. It is well known that periarteritis nodosa occurs at all ages; at the age of 18 months, however, it is unusual. While many types of vascular lesions may occur,[1] multiple encephalitic lesions with necrosis and gliosis were not noted. Also, lipoid deposits cells[2] occur, but not usually as in this case in lymph nodes, spleen and vascular walls resembling the lipoid dyscrasia, Niemann-Pick disease.

Report of Case

The patient was a first child, born by breach with difficulty and considerable trauma. The birth weight was recorded as 9 pounds 4 ounces, and there was bilateral Erb's palsy with gradual recovery. At the age of 2 weeks there was a somewhat widespread impetigo with generalized lymph adenopathy. At 2 months there was an aural infection, at 8 months mumps and conjunctivitis and at 12 months pronounced cervical adenopathy. During this period there were frequent colds. Development seemed normal the first six months. The child seemed to take no interest in sitting or crawling although he appeared as a rule bright and cheerful. Fever accompanied both colds and teething.

The present illness began with lethargy and fever, which increased to 106 F. at the time of death, six days later.

On physical examination, the child lay quietly, had a stary look and responded only to pain stimuli and movement; the right hand was extended and was not moved as much as the left. There was retinitis pigmentosa, and the right upper lid appeared ptosed. The pharynx was moderatcly injected. The spleen was enlarged and extended one finger below the umbilicus. The liver was enlarged two fingers below the costal margin. There was great resistance of movement of the muscles of the legs. The neck was slightly stiff, and there was a suggestion of stiffness of the back. There was a moderate Brudzinsky sign and fanning of the toes. There was 3 plus enlargement of the glands on the right side of the neck, 2 plus enlargement of those in the left axillary region and 1 plus enlargement of the right axillary glands. All glands were firm.

The blood count revealed increasing anemia and leukopenia only slightly controlled by transfusions. The urine showed a heavy trace of albumin. In the spinal fluid there was a slight increase in protein, and the heterophil antibody test gave negative results. A bone marrow biopsy was non informative. A lymph node biopsy showed storage cells taking a fat stain and comparable to those seen in Niemann-Pick disease.

Necropsy Findings.—Positive findings included enlarged lymph nodes with vacuolated deposit cells, edema and congestion of the lungs, and slightly enlarged spleen with groups of storage cells similar to those in the lymph nodes. Most prominent were the vascular lesions present. These were conspicuous in the liver, kidneys, heart, brain, lungs and vessels not associated with organs. It is probable that they would have been found elsewhere with further search. The lesions were of two types; those noted in the brain and those noted elsewhere.

The lesions of the brain were striking because of mononuclear cell infiltrate of Virchow-Robin spaces surrounding necrosis and fresh gliosis. The lesions elsewhere



Fig. 1.—Note the many infarcts of the kidney.

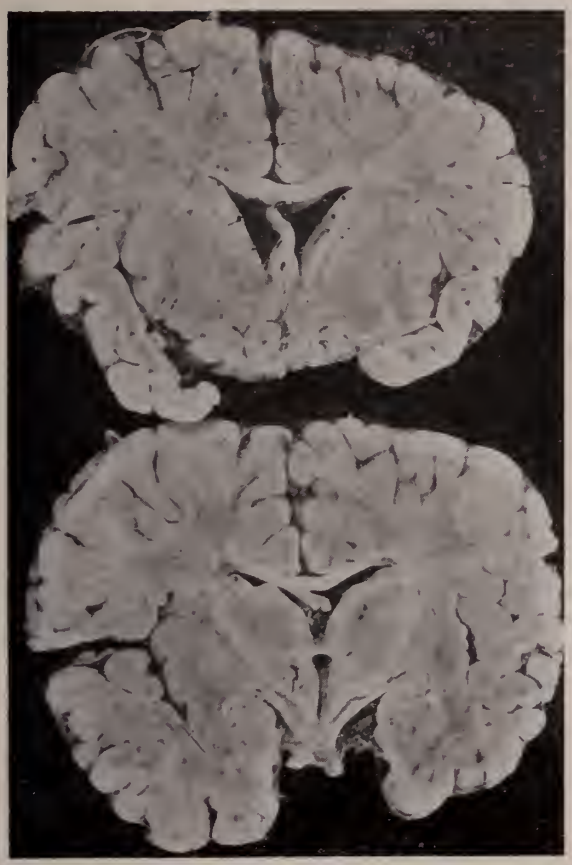


Fig. 2. — Note black accentuated small vascular areas. In these areas one observes microscopically infiltrate of Virchow-Robin spaces with mononuclear cells largely of reticular type and peripheral to this necrosis and early gliosis.

were striking because of deposit cells in the walls of the vessels, cellular infiltrate surrounding the vessels and in the walls, fibrosis, hyaline degeneration ("fibrinoid" collagen) of the walls, thrombosis and organization. The cellular infiltrate showed mononuclears and some polymorphonuclears, but eosinophils were not in evidence. The result of obliteration was in evidence in the infarcts of the kidneys as illustrated in figure 1 and the vascular lesions in figures 2, 3 and 4. The terminal event was congestion, edema of the lungs and early pneumonia. The vascular lesions were accompanied by anoxic lesions in proportion to their occlusion of the areas supplied.

Discussion

A case of periarteritis nodosa is reported because of the unusual manifestations. This name is given because it seems the only category in which to place the collection of manifestations illustrated. The only possible etiologic factor would appear to be the frequent infections. If these were responsible, it must be presumed that this child presented an extremely suitable soil. No outstanding symptom, sign or detail in history would seem to indicate that allergy existed in this case to a greater degree than in cases generally.

Salient features which occur in cases of periarteritis nodosa reported to date are:

1. A basic lesion, arterial, occurring at many sites for reason unexplained; the selectivity of lesions of this type for smaller vessels and capillaries (here with lesions comparable to those described as allergic angiitis[3]); and the frequency of occlusion of end vessels with infarction.
2. The frequency of succession of symptoms at different sites, often with freedom of distress between the attacks.
3. The implication that allergy, therapeutic agents as antibiotics, sulfonamides and thiouracil might be factors.
4. The frequent occurrence of infections as colds and respiratory infections.[4]
5. The frequent reports of eosinophilia as linking with allergy although eosinophils are not necessarily increased or prominent in the lesions; the vascular lesions in eosinophilic granulomas.[5]
6. The production of comparable vascular lesions in laboratory animals.[6]



Fig. 3. — Blood vessels of brain. Note infiltrate of cells in Virchow-Robin spaces and distal to this necrosis and early glial response.



Fig. 4.—Small blood vessels. Left. Artery in neck. Note inflammatory infiltrate of wall, hyalinoid change and deposit cells. Right. Blood vessel of liver. Note hyalinoid change of wall and inflammatory infiltrate about vessel.

Conclusion

An unusual case of periarteritis nodosa is recorded. It is designated periarteritis nodosa since this appears to be the only category in which it can be placed at present. Since the designation periarteritis covers too broad a field, a reclassification would seem advisable when more knowledge of vascular disease is available. Probably a general term angiitis would be best with subclasses.

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Drawer 873.

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The Enlarged Prostate and Its Surgical Management

S. Joseph Pearlman, M.D.
MIAMI

This presentation will attempt to acquaint the general practitioner with the advances and newer methods that have been developed in the surgical management of the enlarged prostate. Fortified with this knowledge, the family physician will be in a better position to reassure his patient and urge him to seek surgical intervention before the occurrence of serious complications.

Little is known regarding the etiology of this condition despite the numerous studies made. The theory commonly accepted today is that some endocrine imbalance exists between the pituitary and testis.

The enlarged prostate gives rise to signs and symptoms suggesting either irritation or obstruction. The latter may be due to carcinoma, fibrosis, or hyperplasia.

The surgical specimens in the benign enlargements are reported by the pathologist as adenoma, adenofibroma, or fibroadenoma. The term prostatectomy is therefore a misnomer. Adenectomy might be more appropriately used. In order to conform to the standard nomenclature, I employ the term subtotal prostatectomy to distinguish it from the radical total prostatectomy for carcinoma, in which the entire prostate, including the true, false, and surgical capsules, is removed.

Preoperative Survey

Present day urologists are reluctant and find it unnecessary to rush a patient into the operating room for surgery without knowing anything of the patient's physical status. The preoperative work-up, which is as important as the operative procedure itself, can be carried out at the office or hospital, depending upon whether the patient presents himself in chronic or acute urinary retention. The following information is deemed essential:

1. A complete urinalysis, to include culture and a Gram stain.
2. An estimation of the residual urine.
3. A complete physical examination.
4. A rectal examination to determine the size, shape, consistency and fixity of the prostate. A gentle massage of the prostate is made, and the expression is examined for pus, blood and organisms.
5. Excretion urography to outline the upper part of the urinary tract.
6. The lower portion of the urinary tract is outlined by means of cystograms, aerograms and cystourethrograms.
7. A two hour intravenous phenolsulfonphthalein test is then made, with plotting of the curve of excretion at fifteen minute intervals.
8. Blood chemistry determinations are then made to include nonprotein nitrogen, sugar, chlorides, and serum acid phosphatase.
9. An electrocardiogram, cardiac evaluation, and a roentgenogram of the chest are then obtained.
10. Cystoscopy should not be necessary unless to clear up some doubtful point in the history or physical examination, but, if indicated, it should be done at the hospital, preferably after an anesthetic has been administered.

In acute urinary retention, when the patient is about 50 years of age, obstruction of the neck of the bladder, usually an enlarged prostate, should be suspected. In younger persons, stricture of the urethra, a sequela of an old gonorrheal infection, is usually the cause. To relieve the patient in acute retention a Fr. 14 or 16 Foley catheter is used and left indwelling, withdrawing the contents of the bladder gradually. Occasionally catheteri-

Read before the staff of the Edgewater Hospital, Miami, May 15, 1951.

zation may be difficult or even impossible. Trocar cystostomy then becomes imperative and can be done through a small incision under local anesthesia, with introduction of a small Foley catheter through the trocar. This procedure is innocuous compared to a difficult catheterization except, however, in cases in which operations have previously been performed in the suprapubic region.

When the symptoms of frequency, nocturia, urgency, and difficulty in urination are more pronounced and the residual urine measures 2 ounces or more, operative intervention is indicated. The enlarged gland felt by the examining finger in the rectum is graded from 1 to 4 depending upon the degree of protrusion. The gland is also graded from 1 to 4 when the extent of intrusion into the urethra or bladder is viewed through the urethroscope.

Methods of Removal

Four methods are employed today in the removal of the enlarged prostate. These are suprapubic, perineal, transurethral and retropubic prostatectomy. The advantages and disadvantages of each procedure are presented.

The suprapubic prostatectomy is the easiest to learn and to perform, and often with a patient whose physical condition is below par, a two stage procedure becomes necessary. The enucleation is a blind procedure, and reconstruction of the neck of the bladder is difficult. The one stage procedure in the patient who is in better physical condition is accompanied by more shock and greater loss of blood. A portion of the vas deferens on each side is excised between two ligatures through small scrotal incisions as a prophylactic against postoperative epididymitis. This procedure is carried out with all four methods of prostatectomy.

Perineal prostatectomy is an excellent operation in the hands of surgeons trained in this method. It is a one stage procedure, and there is a relatively smooth postoperative course. This operation is most frequently followed by sexual impotence, and often closure of the fistula takes a long time. Urinary incontinence frequently follows the radical operation and occasionally occurs in the benign subtotal prostatectomy. The dressings are messy because the incision is just above the anus.

Transurethral prostatectomy is the most difficult to learn and to perform, and even the most experienced resectionists advise against attempting to remove the gland with grade 4 enlargement by this method but will tackle the gland with enlargement ranging from grade 1 to grade 3. The complications with this procedure are:

1. Hemorrhage, which is often severe and can cause exsanguination in a few hours. Late hemorrhage may occur in four to five days, often ten to twelve days, and occasionally two to three weeks. This is usually due to sloughing of infected tissue or extensive coagulation.
2. Infection for prostatitis is practically always associated with hyperplasia and may add to the symptoms of frequency and urgency. The retention catheter also promotes infection, and especially so when the residual urine is infected.
3. Incontinence frequently follows this procedure and is due to direct injury to the external sphincter when the resection is carried too far distally in front of the verumontanum. Damage to the external sphincter may also be caused by overdilatation of the urethra by the large caliber resectoscope employed, or from traction with the Foley catheter.
4. Hemolysis is a serious complication, terminating fatally in many cases. The irrigating fluid enters the general circulation through the venous sinuses in the prostatic capsule, or through the open veins in the prostatic bed. This produces hemoglobinemia and the kidney of shock described as lower nephron nephrosis.
5. Perforations of the bladder frequently occur, necessitating immediate suprapubic cystostomy.
6. Perforations into the rectum are common, resulting in rectourethral fistulae.
7. Strictures of the urethra are common sequelae.
8. Explosions within the bladder by accumulated gases have proved fatal in a few cases. Because of these complications many urologists now restrict this procedure to cases presenting the following lesions: carcinoma, median bar formations, contracture of the vesical neck, middle lobe and grade 1 and 2 enlargements.

In 1947, Terrence Millin, of London, England, introduced into this country a new approach, the retropubic prostatectomy. This operation has

been received enthusiastically by urologists throughout the country. Its advantages lie in its direct approach to the prostate. The enucleation is carried out without opening the bladder. Hemorrhage can be controlled before incising the capsule. Large vessels on the surface can be seen and ligated. There is no danger of incontinence. Radical excisions can be carried out with this method when biopsy demonstrates carcinoma. The postoperative course is remarkably smooth, and in my series of cases, totaling 40, the patients have been discharged on the fifth postoperative day with a closed and dry wound. Complications with this method are few in number. Periosteitis pubis has been reported, but the incidence of this complication is now decreasing as urologists become more familiar with the operative technic. This complication, I believe, can be avoided if care is taken not to traumatize the periosteum when closing the prostatic capsule. Occasionally a fistula will result, but this can be corrected by reinserting a Foley catheter for an additional two to three days.

Summary

Better results in prostatic surgery are obtained when the patients seek medical aid early and when the preoperative survey is thorough.

The advantages and disadvantages of the four operative methods are discussed.

In my opinion, based on a series of 40 cases, retropubic prostatectomy will become more popular as urologists familiarize themselves with the technic and carry out the indicated procedures faithfully.

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This May Journal carries the new officers and committeemen with the exception of the president-elect, vice presidents, secretary-treasurer and editor of The Journal. The names of these officers are omitted because the May Journal went to press before the election of officers by the House of Delegates, April 30.

All new officers will be listed in your June Journal, as will the personnel of The Journal staff for 1952.

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Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas, Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne, M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey, Jr., M.D., Sec'y., 1951.....*Tampa*

The Journal of the Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION

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NOTICE

This May Journal carries the new officers and committeemen with the exception of the president-elect, vice presidents, secretary-treasurer and editor of The Journal. The names of these officers are omitted because the May Journal went to press before the election of officers by the House of Delegates, April 30.

All new officers will be listed in your June Journal, as will the personnel of The Journal staff for 1952.

Gifts to A. M. E. Foundation

The undersigned attended an all day conference in Chicago, February 17. This conference was the 1952 "kick-off" for the American Medical Education Foundation. Representatives from almost every state medical association were present and your correspondent attended because Dr. Julius C. Davis, chairman of our Committee on Medical Education and Hospitals, was unable to attend. The writer will assume the chairmanship of this committee April 30.

This meeting was most informative and inspiring and important plans were formulated for 1952. Presiding was Dr. Elmer Henderson, president of the American Medical Education Foundation. The history of the Foundation and the results of the work in 1951 were described by Dr. Donald Anderson, secretary-treasurer of the Foundation. An outstanding expert in fund raising, Dr. James Almond, president of the American City Bureau of Chicago, addressed the group. This was followed by a session called "Much to Do in 52" in which the goal, the plan and the mechanics of raising funds for the Foundation were discussed at length.

This meeting impressed the writer anew with the importance of each of us in the Florida Medical Association contributing to the American Medical Education Foundation.

Jack Q. Cleveland, M.D.

Medical Education Fund Campaign

Placing emphasis at the grass roots level, the 1952 campaign of the American Medical Education Foundation for funds for the nation's medical schools now enters the second month of intensive solicitation of the medical profession, scheduled during the period April 1 through June 30. Each state society is charged with the responsibility of conducting its own campaign by methods it knows best, since the individual society is in the best position to judge the type of campaign likely to be most effective among its membership.

Two million dollars is the minimum goal set by the Foundation for this year, "with the realistic figure being near four million." Token gifts will by no means raise such a sum. If leaders at the state and county levels approach the members of the profession individually as well as through mass mediums, a sufficient number of physicians undoubtedly will contribute generously enough to assure this goal from this source alone. Help is

always needed at the local level, especially in a project of this magnitude and importance, and it is believed that members of the Florida Medical Association, along with their colleagues of other state associations, are sufficiently interested in solving their own problems to volunteer to give the necessary time and money so that this worthy undertaking may be crowned speedily with success.

At the initial meeting launching the drive, Dr. James E. Almond of Chicago declared: "It can be said without the slightest fear of contradiction that 1952 will see the greatest total contribution to voluntary philanthropy in our country's history . . . and this stream of dollars will increase in volume with steady annual increment for a long time to come." This outstanding pioneer in the fund-raising field added: "The penalties of leadership cannot compare with its privileges. The men who are taking the initiative in this crusade will have their achievements recognized through the ministry of higher education for generations to come." Who within the Association would deny himself the privilege of participating? Surely, not a single member.

Science Versus Sentiment

It was with particular interest that the editorial eye fell recently upon an article[1] suggesting that the "various medical journals need to give more space and greater expression to sentiment, certainly those at least which are not limited in purpose to the furtherance of pure science." Deploring the present imbalance between science and sentiment, the author thought it justifiable for "medical journals to reprint on occasion the best from Osler, Holmes, Barrett, Sir Thomas Browne, and that stirring tale of the doctor of 'the auld school' found in 'The Bonnie Briar Bush.'" The suggestion is refreshing.

Medicine truly "bespeaks a universal language of the heart." In its transition from a practice largely an art to one predominantly a science, it undoubtedly has sacrificed certain of its essentials. These factors inherent in its traditional influence need to be revived.

Perhaps the major one is sufficiency of time, as this article suggested. It does indeed require a sufficiency of time to sound the soul of man, to listen to those who are sick at heart, to take a personal, intimate interest in each individual patient. A packed appointment book of course precludes the fulfilment of this concept. The overworked physician agrees readily with Omar Khayyam that "the bird of time has but a little way to flutter and, lo, the bird is on the wing." Yet the aim of medicine is to render man physically fit and mentally happy.

Inspired leadership within the profession is another priceless component which needs reviving. Science appears to be crowding out sentiment in medical schools. "Too early and too much does the student learn about the miracle drugs. Less often, if at all, is he embued with the faith and philosophy of the great men of medicine who made medicine great." There is likewise opportunity for inspired leadership in the contacts with younger practicing physicians, and, too, with older ones who are inclined to relinquish the human touch for neoscience.

Who will deny that the primary requisites of a good physician are sympathy and understanding of human problems and the travail of the human heart? Such a physician fulfils his obligations to society only in so far as he appreciates that for his patients a full life is measured not by length alone but also by depth and breadth.

Leaving this country in 1905 to teach at Oxford, Sir William Osler reminded his American colleagues in these words of a noble tradition attributed to the profession by all mankind half a century ago: "Medicine is the only world-wide profession actuated by the same ambitions and pursuing the same ends. . . . A united profession working in many lands has done more for the race than any other body of men." Such a heritage is to be cherished; such influence is to be perpetuated. Righting the imbalance between science and sentiment may well be carrying on in the best tradition.

1. Johnstone, R. T.: Medicine Can Bridge the Sullen Tide, J. A. M. A. 147:911-913 (Nov. 3) 1951.

The Physician of Tomorrow

The slow but progressive evolution of medical intelligence has brought medical thought through successive steps from the hazy horizon of antiquity to the bright light of today, made brighter by tremendous strides in the kindred sciences of chemistry and physics. During the last two centuries, the tendency to study the disease to the exclusion of its host — man, himself — has gradually but constantly developed. With all of the profound changes of the past two decades alone in the practice of medicine, with all of the brilliant contributions of science, there nevertheless appear signs

that the pendulum has begun to swing to a more balanced position. A timely return to a modification of the Hippocratic tendency to view man as a whole, as well as his disease, appears under way.

It has been aptly said that the physician of tomorrow must view disease with the telescope as well as with the microscope. Biologic, sociologic and psychologic influences must take their place beside the bacteriologic and pathologic factors. Medicine has a vital role in reviving a sick society. The social scientists almost uniformly believe that present day conflict between groups and nations results largely from years of cumulative mental immaturity, that for too long men of immature mind have held high office. But they — the psychologist, the sociologist and the cultural anthropologist — think in terms of the group and advocate suitable group disciplines.

The physician, on the other hand, endowed with the means of preventing or curing disease, has the truly grass roots approach to the social problem for he has a peculiar opportunity to help the individual adjust himself to his environment. He is privileged to start at the beginning — with the individual and his family, the smallest unit of society. With the training to resolve psychosomatic problems, he can aid incalculably an ailing society through the basic step of implanting love, harmony and peace of mind within the family.

In the light of the present trend, the future physician will be versed in the humanities as well as the sciences. His success in the science of medicine will parallel his appreciation of its art. Without deviating from the scientific attitude, he will temper the use of his array of scientific facts with a sincere attempt to evaluate their effect on man — the Personality. To a broader, more effective use of these facts than his colleagues of today command, he will add a more comprehensive understanding of the intricate processes which make up the personality of man. As he comes to appreciate the totality of conditions, internal and external, as he takes due cognizance of the varying influences of the manifold reactions in the soil which harbors disease, the essential principle of viewing disease not apart from but with man will triumph, as it should. May he be ever mindful of Hippocrates' wise observation that where there is love of man there is also love of the art of medicine.

Successful Diabetes Seminar

A Seminar on Diabetes Mellitus, presented by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association, the Florida State Board of Health and the Palm Beach County Medical Society, was held in West Palm Beach, March 27-28, 1952. Dr. Howard Root and Dr. Priscilla White of Boston together with Dr. Johen W. Runyan, Jr.. of the United States Public Health Service and Dr. Edward R. Smith of the State Board of Health delivered stimulating lectures, which were particularly well received. Much of the material covered by Dr. Root and Dr. White is incorporated in their new book soon to be published.

The registration for the meeting totaled 81. At a meeting for the public on Thursday night, March 27, there were approximately 350 in attendance.

Twentieth Annual Graduate Short Course June 23-28, 1952

The Twentieth Annual Graduate Short Course will be held at the George Washington Hotel in Jacksonville, June 23-28, 1952. The faculty is as follows:

Medicine: Dr. George S. Mirick, Associate Professor of Medicine, The Johns Hopkins University School of Medicine, Baltimore.

Surgery: Dr. Howard Mahorner, Clinical Associate Professor of Surgery, Louisiana State School of Medicine; Director, Mahorner Clinic, New Orleans.

Pediatrics: Dr. Jay M. Arena, Associate Professor of Pediatrics, Duke University School of Medicine, Durham, N. C.

Obstetrics: Dr. M. Edward Davis, The Joseph Bolivar DeLee Professor of Obstetrics and Gynecology, University of Chicago and the Chicago Lying-in Hospital, Chicago.

Gynecology: Dr. Andrew A. Marchetti, Professor and Chairman of the Department of Obstetrics and Gynecology, Georgetown University School of Medicine, Washington, D. C.

Diseases of the Chest: Dr. H. McLeod Riggins, Associate Clinical Professor of Medicine, College of Physicians and Surgeons, Columbia University, New York.

SCHEDULE FOR SHORT COURSE

HOUR	Monday June 23	Tuesday June 24	Wednesday June 25	Thursday June 26	Friday June 27	Saturday June 28
8:00	**Registration**					
9:00	**Diseases of the Chest** "Recent Advances in, and Basic Concepts of Prolonged Chemotherapy and Resection Surgery for Pulmonary Tuberculosis" Dr. Riggins	**Pediatrics** "Cancer in Childhood" Dr. Arena	**Pediatrics** "Congenital Pyloric Stenosis" Dr. Arena	**Obstetrics** "The Management of the Placental Stage and Postpartum Hemorrhage" Dr. Davis	**Gynecology** "Pelvic Inflammatory Disease" Dr. Marchetti	**Gynecology** "Adenocarcinoma of the Body of the Uterus" Dr. Marchetti
10:00	**Pediatrics** "Accidental Poisoning in Children" Dr. Arena	**Diseases of the Chest** "Some Practical Problems in the Diagnosis and Treatment of Miscellaneous Nontuberculosis Chest Diseases" Dr. Riggins	**Medicine** "Infectious Hepatitis—Clinical Studies" Dr.Mirick	**Gynecology** "Endometriosis and Adenomyosis" Dr. Marchetti	**Obstetrics** "Sterility Investigation" Dr. Davis	**Surgery** "Surgical Lesions of the Neck, Including Goiter" Dr. Mahorner
11:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
11:30	**Medicine** "Primary Atypical Pneumonia" Dr. Mirick	**Pediatrics** "Immunization and Prophylaxis" Dr. Arena	**Obstetrics** "Modern Prenatal Care" Dr. Davis	**Surgery** "Surgical Lesions of the Colon and Rectum" Dr. Mahorner	**Surgery** "A. The Differential Diagnosis of Peripheral Vascular Disturbances B. Their Surgical Treatment" Dr. Mahorner	**Gynecology** "Ectopic Pregnancy" Dr.Marchetti **Surgery** "Experiences with Gastric Surgery" Dr. Mahorner
12:30	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**	
2:00	**Pediatrics** "Rheumatic Fever" Dr. Arena	**Medicine** "The Uses and Abuses of Antibiotics" Dr. Mirick	**Medicine** "Infectious Hepatitis—Experimental Studies" Dr. Mirick	**Obstetrics** "The Conduct of Abnormal Labor" Dr. Davis	**Obstetrics** "The Diagnosis and Treatment of Bleeding in Late Pregnancy" Dr. Davis	
3:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	
3:15	**Medicine** "Drug Resistance of Micro-organisms" Dr. Mirick	**Diseases of the Chest** Subject to be announced Dr. Riggins	**Pediatrics** "Hemolytic Anemias in Childhood" Dr. Arena	**Surgery** "A. Varicose Veins B. Thrombosis and Postthrombophlebitic States" Dr. Mahorner	**Surgery** "Surgery of the Bilary Tract" Dr. Mahorner	
4:15	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**	
4:30	**Disease of the Chest** "The Diagnosis and Present Medical and Surgical Treatment of Acute and Chronic Suppurative Pulmonary Diseases" Dr. Riggins	**Medicine** "The Adrenal Steriods and Infection" Dr. Mirick	**Obstetrics** "The Management of Abortions" Dr. Davis	**Gynecology** "Abnormal Uterine Bleeding" Dr. Marchetti	**Gynecology** "Gynecologic Conditions Complicating Pregnancy" Dr. Marchetti	

State Fair Exhibit

The fact that the American public spends about 24.6 billion dollars a year for such things as tobacco, alcohol, toilet articles and recreation as compared with 7.9 billion for medical care was forcefully brought to the attention of thousands of visitors who attended the Florida State Fair Feb. 5-16 at Tampa.

This was accomplished by the first Fair Exhibit ever sponsored by the Florida Medical Association — an exhibit which combined color, humor and action to effectively tell its story.

The exhibit, occupying a 45 foot center space in the Pan-American Building, was manned by a staff of 22 technicians, 48 student nurses and 58 members of the Woman's Auxiliary to the Hillsborough County Medical Association, to provide free blood grouping and typing and blood pressure determinations to the public. Members of the staff of the Association's Bureau of Public Relations were in continuous attendance from the opening day until the Fair closed.

During the 11 day run of the Fair, 11,470 persons took advantage of this service — 7,630 having had their blood pressure checked and 3,840 being recorded as having their blood typed. The results of the tests were given to the applicants on pocket-size cards on which was printed "Courtesy of the Florida Medical Association." In addition, more than 15,000 pieces of medical literature, stamped with the Association's name, were distributed.

Blood pressure and typing activities terminated each day at 8 p.m. From that hour interest centered on the exhibit. Square white bases, topped with revolving gold colored stacks of coins, heightened with humorous cut-out figures, made people stop to look. They saw the long gold-on-green sign "Sponsored by the Florida Medical Association" and then the smaller signs in the same colors that gave the essence of the story: drugs $1.4 billion, hospital care $1.8 billion, physicians' services $2.3 billion, all other medical care $2.4 billion and the total $7.9 billion. Then was shown the money spent for pleasure: toilet articles $2.2 billion, tobacco $4.3 billion, alcohol $7.9 billion, recreation $10.2 billion — a total of $24.6 billion. These figures were taken from U. S. Department of Commerce estimates for 1949.

Many people stopped and jotted down these figures. Others remarked: "I didn't know we were having that big a time, and paying so little to keep in condition to have it."

For those who could not attend the Fair, the local daily newspapers, a radio station and the wire services took the story to them. Scarcely a day passed during the Fair that some mention of the exhibit was not carried in the paper. Several feature stories, with photographs, were also published. For a Sunday afternoon radio program, a station featured the electrical show and the Florida Medical Association's display. Preceding opening of the Fair, the major dailies in the state carried a coupon which would entitle the bearer to a free blood pressure check.

Blood grouping and typing was under the direction of Dr. James N. Patterson, assisted by Dr. Wray D. Storey, both of Tampa. Mound Park Hospital School of Nursing, St. Petersburg, and the Gordon Keller School of Nursing, Tampa Municipal Hospital, provided student nurses for taking blood pressures. The Southwest Florida Blood Bank, Tampa Municipal Hospital and the private laboratory of Drs. Herbert R. Mills and James N. Patterson, Tampa, furnished technicians for grouping and typing.

Idea for the Fair exhibit was first conceived by President David R. Murphey, Jr., and Dr. Eugene B. Maxwell, chairman, Committee on Public Relations, both of Tampa. Dr. Maxwell briefly discussed the exhibit plan before a meeting of his committee at Hollywood during the 1951 convention of the Association. It was further elaborated upon and explained by Dr. Maxwell at each of the medical district meetings in October. The idea had the unanimous approval of the Board of Governors of the Florida Medical Association.

In November Dr. Murphey called together physicians, newspapermen, cartoonists, artists and exhibit makers to discuss what could be done. The group agreed to use an idea which appeared originally as a cartoon in *Medical Economics*. It was decided that the story told by the cartoon — the comparative cost of medical care — could be sharpened, and that the theme itself could be broadened by adding four original cartoons to the exhibit. These drawings would be mounted on the exhibit's base and lighted from the back to make them clear.

Byron Stephens, an artist on the staff of the Tampa *Tribune*, was made general supervisor in charge of building the exhibit. He was requested to prepare a working sketch. George White, a cartoonist, was asked to prepare the four drawings. After Mr. Stephen's sketch had been approved by the Board of Governors, the contract for construc-

tion was awarded. On Jan. 27, 1952, a week before the Fair was to be opened, the exhibit was ready for a preview.

In the meantime Dr. Murphey and Dr. Maxwell made arrangements with members of the Woman's Auxiliary to the Hillsborough County Medical Association to be on duty at the exhibit. They also arranged for Mound Park and Gordon Keller to furnish student nurses. This gave these training schools the opportunity to contact many prospective students.

During the 11 day showing, the exhibit had a host of compliments — from Fair officials, both local and out of state, from educators, from the average man and from physicians.

One Auxiliary member summed up all their reactions: "This is the most appreciative crowd I have ever seen."

* * *

After the close of the Fair, the following night letter was received from Mr. Lawrence W. Rember, Field Director of the American Medical Association Department of Public Relations. Mr. Rember recently was in Florida for a week. He spent his first two days at the Association's office in Jacksonville where he conferred with department heads. He then proceeded to the State Fair at Tampa where he had opportunity to make first hand observations of the effectiveness of the exhibit.

1952 March 27, A. M. 1:26
Dr. David R. Murphey, Jr., President
Florida Medical Association
442 West Lafayette Street
Tampa, Florida

Your medical exhibit at the Florida State Fair had everything that makes a public exhibit successful. It had action and color. It was dignified in its message and in its green, gold and white attire. Every part of it was truly worthy of the ethical and honored profession which it represented. Yet it possessed that vital quality of getting through to the mind and emotions of the common man — who made up the vast majority of that 1,000,000 plus men and women who went through the turnstiles of the Fair.

The revolving piles of money; the identifying cut-outs on the top of them; the added eye-catcher cartoons dramatizing medicine's progress; the nearness of the modern doctor; the benefits of health insurance; and the drug miracles of private enterprise; the compelling facts contrasting how much less people



Association Exhibit — Florida State Fair, Tampa, Feb. 5-16

pay for health services than they do for personal pleasure; the strategic location; the lighted ribbon "Medical Information" ceiling signs; the audience participation; the facilities for sitting and absorbing the message; the clockwork precision and the highest type of personnel manning the blood pressure and blood typing tables all attest to the thoroughness, the creativeness, the professionalness, the inevitable effectiveness of the exhibit.

Is it any wonder that the word got around that it was "the hottest thing at the Fair."

One basic human motivation often makes an exhibit highly successful. You tossed everything at them in the persuasion book. You appealed to curiosity, self preservation, the desire to get something free (acquisitiveness). You achieved the ultimate in publicity — in maintaining the flow of customers and enlarging their numbers by the band wagon device — by such mechanisms as snaring Hal Boyle, famed feature writer of the Associated Press, and U. S. Senator George Smathers, and spreading their approval and their appeal through pictures and through words in the daily press.

For the first time many Floridians and out-of-state guests gained a new, positive association between the public welfare and the medical profession of your state. The exhibit rendered a real service to the more than 11,000 people who had their blood typed and pressured. The record cards given out will serve as a personal reminder in women's purses and men's billfolds for months and even years to come of the free favor rendered by the doctors of Florida. They will also long remember the dramatized truth on medical care costs versus other expenditures and how favorable to the Florida citizen's pocketbook the purchase of medical care is.

Judge and maid alike came through the line and walked a common medical good will path.

When you told me that the literature you were passing out at the exhibit could not be found anywhere discarded on the Fair grounds, I had to see it with my own eyes to believe it. So on Saturday I did. I found . . . [from various organizations] . . . folders and pamphlets scattered about on the floors in Fair buildings and on the open Fair grounds. But I did not find one piece of tossed away medical literature. I knew then what the mother meant when she said to the child who picked up the literature which had just been handed to her at the end of the blood typing table: "Lay that down; mama has to read that."

Yes, it's to your credit that so many thousands of folks got something from the medical people while they were attending the State Fair of which they are proud and which to many of them is an important experience in their lives.

It can be said in truth that in no State Fair in the United States to my nationwide knowledge has a medical exhibit attained such heights of public appeal or obtained so much good will for the doctors and the medical profession as did the medical exhibit designed and sponsored by the Florida Medical Association.

It was a privilege and an education to be present. I shall carry word of it throughout the land for the benefit of other societies.

Larry Rember

Progress in Emergency Call Programs

Provision for emergency medical treatment poses a primary problem for the medical society. While emergencies are few in number compared to all other medical care services, their inherent possibilities for unfavorable criticism are not to be ignored. The reputation of the whole profession suffers when the layman, unable to obtain the services of a physician whenever he needs them, complains that physicians are not serving the public properly. His argument carries the same weight even though a physician may have been available, but he did not know how to contact him. An important project for any medical society, therefore, is the development of an efficient emergency call plan as a means of assuring the public that medical care will be available when needed.

It is gratifying to note the rapid strides made recently in developing emergency call systems. In 1948, approximately 60 medical societies reported having a formal plan for handling emergency and night calls; the estimated number in 1949 was between 100 and 120; and in 1950 it had risen to more than 350. Among 364 medical societies reporting emergency call plans to the American Medical Association Committee on Medical Service,[1] over 80 per cent of the large societies, with 200 and more members, now have emergency call plans. Slightly less than half, however, of the societies whose membership ranges from 100 to 200, and only 13 per cent of those with less than 100 members, have such a plan.

There is obviously need for more work on the problem, especially among the smaller medical societies. To learn the various methods employed in handling the plans, the Council on Medical Service recently surveyed the emergency call methods employed by 143 county medical societies, the majority of them in the smaller societies. The information is now available for the medical society officers at the Council office and is being prepared in pamphlet form designed particularly for county medical societies.

Local conditions determine the type of plan. The central dispatching office may be a hospital, a private telephone service or a society owned and operated telephone service. In some communities the regular physician-patient relationship suffices for emergencies. Whatever the plan, the definite function of the medical societies is to make sure that no emergency call goes unanswered. Not only should they provide for unity and direction of indi-

vidual physician effort, but they should also publicize the program widely and continuously to keep the public aware of it and how it should be used. At the outset, it should be made clear that the plan is for use only when actually necessary. To be successful, emergency call plans require the cooperation of the public as well as of physicians and their medical societies.

1. Emergency Medical Call Programs. Council on Medical Service. J. A. M. A. 148:491-492 (Feb. 9) 1952.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Aten, William G., Jr., Miami
Bechtel, Jack T., Eau Gallie
Bielek, Miles J., Fort Lauderdale
Blades, James E., Nokomis
Brownlee, Harry G., Zephyrhills
Clifford, William J., North Miami
Cole, J. P., Tampa
Crosby, William R., Tampa
Derrick, Walter A., Orlando
Dunton, Loren A., DeLand
Edwards, Joshua L., Durham, N. C.
Hege, John R., Jr., Hollywood
Ingram, J. M., Jr., Tampa
Jensen, Edwin J., Miami
Johnston, Harold W., Orlando
Juers, Arthur L., Miami
Kay, John H., Panama City
Kelley, Edmund P., Sarasota
Knight, Victor H., Jr., Tampa
Marsh, John G., Orlando
Milloff, Bernard, Hollywood
Neill, James M., St. Petersburg
Polk, Rothwell C., Jacksonville
Sheehan, Frank T., Miami
Tobin, Walter R., Miami
Vaughn, James A., Jr., South Miami
Wallace, Thomas H., Sarasota
Wells, Carl H., Jacksonville
Zick, Luther H., Tampa

YOUR BLUE SHIELD

Blue Shield Liaison Committees

One of the things that is to be developed from the "Physician's Personal and Professional Data Sheet" recently circulated by the Florida Blue Shield Plan will be the development of liaison committees in the county medical societies. Similar committees are working very satisfactorily in other parts of the country and do an excellent job in bringing the Plan and the Doctor closer together. The fine cooperation that has been experienced by the Plan in the past leads the Plan to believe that the committee will be very successful here in Florida. These committees, when set up by the society presidents, will form a nucleus of Blue Shield information and will be close at hand for the doctors in each community. Some societies have already appointed their liaison committees, and in the not too distant future, further steps toward a working arrangement will be made.

Should you desire more information on these committees, contact the Florida Blue Shield Plan in Jacksonville at Post Office Box 1798.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Harold Rand of Miami announce the birth of a daughter, Jennifer May.

Dr. and Mrs. Jackson L. Allgood, Jr., of Jacksonville announce the birth of a daughter on March 8.

Dr. and Mrs. Samuel M. Day of Jacksonville announce the birth of a son, Arthur Lennard, on April 9.

Deaths — Members

Thomson, Wm. R., Miami ..... March 17, 1952
Perdue, J. Randolph, Miami ..... March 27, 1952

Deaths — Other Doctors

Burkett, Wyatt T., Dothan, Ala. ..... October, 1951
Williams, Lois F. D., Fort Pierce ..... Nov. 18, 1951
Dux, Henry M., Jacksonville ..... March 18, 1952

STATE NEWS ITEMS

The second annual seminar on recent advances in diagnosis and treatment, sponsored by the Mount Sinai Hospital of Greater Miami, will be held May 22-24 at the Delano Hotel, Miami Beach.

Eight outstanding lecturers from leading medical schools throughout the nation will conduct the seminar. Subjects to be presented include gastro-intestinal diseases, diabetes, hematology, surgery, thyroidology and electrolyte disturbances.

Invitation is extended by the Seminar Committee to all Florida physicians. Registration is $20 with attendance at the banquet optional. Interns and residents will not be required to pay a registration fee.

For additional information contact Dr. Jandon Schwarz, Mount Sinai Hospital of Greater Miami, 4300 Alton Road, Miami Beach 40.

Dr. Arthur J. Butt of Pensacola recently gave a series of lectures on the "Management of Renal Lithiasis," at the Los Angeles Postgraduate Medical Assembly.

Drs. Earl R. Templeton of Miami Beach and DeWitt C. Daughtry of Miami were among a group of physicians making a tour under the sponsorship of the World Medical Association to bring the latest medical technics and developments to physicians in Cuba, the Dominican Republic, Venezuela and Panama.

Dr. Merritt R. Clements of Tallahassee addressed a recent meeting of naval reservists at Dale Mabry Field. Dr. Clements, a Lieutenant Commander in the naval reserve, spoke on "The Navy Doctor."

Drs. J. Brown Farrior and Richard A. Bagby of Tampa have been awarded accreditative diplomas for their exhibit on ear surgery at the third Pan-American Congress of Otolaryngology in Havana, Cuba, during January. Their exhibit was given second award in the scientific exhibit at the meeting.

Dr. James C. White of West Palm Beach spoke on heart disease, its treatment and the present research by the American Heart Association, at a local Business and Professional Women's Club meeting in February.

Drs. John F. Lovejoy, George I. Raybin and Eugene M. Frame of Jacksonville were among the physicians attending the sixteenth annual Crippled Children's Clinic, sponsored by Haisley Lynch Post 16, American Legion and Auxiliary, in Gainesville. The clinic is held in Gainesville each year by the Florida Crippled Children's Commission and is for all children in the county.

Dr. Morris H. Blau of Miami, representing the Dade County Medical Association, spoke at a recent meeting of Roosevelt Temple 33, Pythian Sisters, of that city. A movie on cancer was also shown.

Dr. David R. Murphey, Jr., of Tampa, president of the Association, spoke at a meeting of the Rotary Club of Dunedin on March 4. Dr. Murphey, who was introduced by Dr. Harold E. Winchester of Dunedin, traced the course of medical history in America from its feeble beginning to the present.

Four members of the Dade County Medical Association described medical services available to Dade County residents at a recent meeting of the Dade County Health Council. They were Drs. John D. Milton, president of the Medical Service Bureau; Ralph W. Jack, president-elect of the Dade County Medical Association; Wiley M. Sams, chairman of the County Medical Association's grievance committee; and Richard F. Stover, chairman of the public health advisory committee.

Drs. Henry L. Harrell of Ocala and Walter W. Sackett, Jr., of Miami attended, as official representatives from Florida, the Annual Convention of the American Academy of General Practice at Atlantic City, March 23-27.

A Crossroads Cancer Seminar is being sponsored by the American Cancer Society, Florida Division, the Florida State Board of Health, the County Medical Societies and the health departments in the counties concerned. Meetings will be held in St. Augustine, May 12; Eustis, May 13; West Palm Beach, May 14; and Key West, May 15. The speaker at these meetings will be Dr. Walter J. Burdette of the Louisiana State University School of Medicine, New Orleans.

Dr. Courtlandt Berry of Orlando is on leave of absence from his practice in order to set up a cancer detection program for women at the University of Puerto Rico Medical School, San Juan.

Dr. Carl C. Mendoza of Jacksonville spoke and showed films on cancer to faculty members and students of the Jacksonville Junior College at a recent student assembly.

Dr. Frank L. Quillman of Sanford, Director of the Seminole County Health Unit, spoke to fellow members of the Sanford Lions Club recently. He explained the need of proper sewage disposal facilities to prevent future epidemics of typhoid or other diseases in the area.

Dr. P. G. Batson, Jr., of Pensacola spoke on "Medical Care of Polio Patients During Convalescence" during the third session of the Institute on Polio Care conducted at the Crippled Children's Convalescent Home in Pensacola.

Drs. William H. McCullagh and Matthew E. Morrow, Jr., of Jacksonville took part in a play depicting what happens to the mentally ill in Duval County at a meeting of the Northwest Florida Association for Mental Health in February. Dr. Sullivan G. Bedell of Jacksonville discussed the implications of the play after its presentation.

Dr. George W. Elarbee, Pahokee, was honored recently by the Pahokee Lions Club when they dedicated the club luncheon program to him and designated the day as Dr. George Elarbee Day. Though 78 years of age, Dr. Elarbee still practices medicine, serving his community four hours daily. During his 52 years of practice, he has delivered more than 2,300 babies.

Mr. Aubrey D. Gates, field director of the A. M. A. Council on Rural Health, visited Florida recently, attended a staff conference at the Association's office in Jacksonville and then proceeded to Tampa to confer with President David R. Murphey, Jr., and Dr. Eugene B. Maxwell, Chairman of the F. M. A. Committee on Public Relations, on the Association's Rural Educational Program.

Dr. Phillip W. Horn of Jacksonville talked on cancer to members and guests of the Lake Shore Dads Club on April 3. Dr. Horn demonstrated by chart how the incidence of cancer has increased in recent years. He described symptoms which each person, particularly those in the upper age groups, should watch for, and which when detected, should be taken immediately to a physician.

Dr. Donald W. Smith of Miami addressed a meeting of the South Florida Veterinary Society in March.

Dr. Grayson C. Snyder of Blountstown was recently elected vice president of the Blountstown Rotary Club.

Dr. Cornelia M. Carithers of Jacksonville spoke on "Sex Education for Children" at a meeting of the Junior Woman's Club of Jacksonville in March.

Dr. J. Clifford Boyce of Sanford spoke on the needs of underprivileged children at a recent meeting of the Kiwanis Club of Sanford.

Dr. Sidney Stillman of Jacksonville spoke on "Know Cancer's Seven Danger Signals" at the March meeting of the Lola M. Culver P.-T.A.

Dr. Fred H. Albee, Jr., of Orlando attended the Regional Meeting of the American College of Surgeons in San Juan, Puerto Rico, February 27-30.

Drs. James C. Lanier and Lorenzo L. Parks of Jacksonville were speakers at the opening session of a course in the current nursing methods of Polio treatment for Northwest Florida nurses in Jacksonville in March.

Dr. Kenneth A. Morris of Jacksonville presented a paper on "Surgery of the Pancreas" at the Southeastern Surgical Congress in Atlanta in March.

At its meeting in February The Greater Miami Eye, Ear, Nose and Throat Society, now in its fifth year, elected the following officers: President, Dr. Kenneth S. Whitmer of Miami; Vice President, Dr. John R. Richardson of Miami; Second Vice President, Dr. M. Austin Lovejoy of Fort Lauderdale; and Secretary-Treasurer, Dr. James H. Mendel, Jr., of Miami. The scientific program consisted of a discussion of "Unilateral Exophthalmos" with presentation of 10 cases by Dr. Ralph E. Kirsch and Dr. William Steinman of Miami, and a discussion of "Audiogram Interpretation" by Dr. Arthur L. Juers of Miami. Twenty-six members were present.

At a recent meeting of the Florida Society of X-Ray Technicians in Jacksonville, Dr. A. Judson Graves of that city delivered the address of welcome. Dr. Ivan Isaacs of Jacksonville spoke on "Angiocardiography," and Dr. Wade S. Rizk, also of Jacksonville, spoke on "Useful But Infrequently Used Positions in Skeletal Radiography."

Dr. Sherman B. Forbes of Tampa attended the annual meeting of the Georgia Society of Ophthalmology and Otolaryngology in Savannah on March 7 and 8.

Drs. Wilson T. Sowder and Frank G. Slaughter spoke at a meeting of the Florida Anti-Mosquito Control Association in Jacksonville recently. Dr. Sowder spoke on an effective mosquito control program, and Dr. Slaughter gave a talk on current health problems and their relationship to mental and emotional stress.

Dr. Milton C. Maloney of Jacksonville spoke on Cancer at a recent meeting of the Jacksonville Beaches Junior Woman's Club.

Dr. Russell B. Carson of Fort Lauderdale was elected president-elect of the Southeastern Section of the American Urological Association at the sixteenth annual meeting in Boca Raton, April 2-5. Dr. Carson had been serving as secretary-treasurer.

COMPONENT SOCIETY NOTES

Dade

At the regular May meeting of the Dade County Medical Association, the liaison Committee of the Dade County Bar Association presented a panel on the following subjects: "Confidential Relationship Between Doctor and Patient," "Duties and Responsibilities of the Court-appointed Physician," "The Duties of the Expert Medical Witness," and "The Responsibilities of Furnishing Medical Reports."

DeSoto-Hardee-Highlands-Glades

At the March meeting of the DeSoto-Hardee-Highlands-Glades Medical Society, Dr. S. L. Watson presented a paper on "Lesions of the Cervix."

Duval

The Duval County Medical Society is cooperating with the Jacksonville-Duval County Civil Defense Council in sponsoring a second casualty team training course. Faculty for the nine-lecture course includes Drs. James V. Freeman, George W. Croft, J. Q. U. Thompson, Jonathon H. Wood, Thomas M. Irwin and Milton C. Maloney.

At the regular April meeting of the Duval County Medical Society, Dr. J. Hillis Miller, President, and Mr. Jefferson Hamilton, Architect, of the University of Florida, Gainesville, spoke on "Recent Developments in Medical Education in Florida," and Mr. DeWitt Dawkins spoke on "Housing Problems in Jacksonville." Dentists of the Northeast Florida District and members of the Jacksonville Dental Society were invited to attend the meeting.

Manatee

Dr. Theodore VanDellen, assistant professor of medicine and assistant dean of the Northwestern University Medical School, spoke on "The Follow Up Treatment of Coronary Thrombosis" at a combined meeting of the Manatee and Sarasota County Medical Societies, in March. Dr. VanDellen is author of the syndicated column, "How Is Your Heart?"

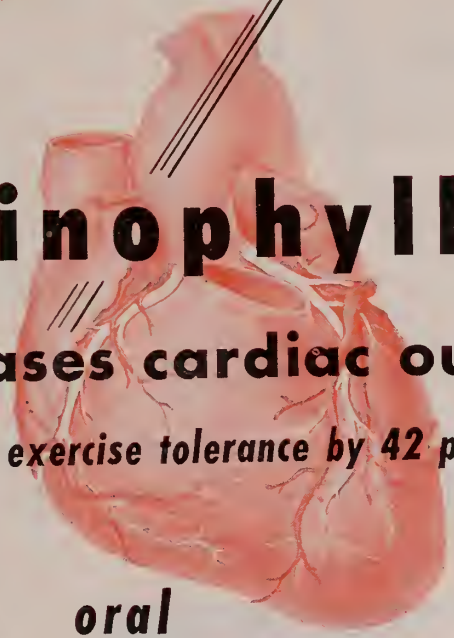
(Continued on page 812)

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1. Kissin, M.; Stein, J. J., and Adelmon, R. J.: Angiology 2:217 (June) 1951.
2. Rickles, J. A. J. Florida M.A. 38:263 (Oct.) 1951.

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From where I sit, it's only too easy to forget how to do something—even as simple as milking a cow—if we don't keep at it. And that goes for practicing tolerance, too. Like forgetting our neighbor has a right to decide for himself—how to practice his profession . . . whether or not to have beer with his meals. If we don't keep the other fellow's point of view constantly in mind we're liable to have our freedoms "milked" away.

Joe Marsh

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(Continued from page 810)

Marion

The regular monthly meeting of the Marion County Medical Society was held at the Ocala Highlands Hotel on March 18. Guest speaker was Dr. Bruce Logue, assistant professor of medicine, Emory University School of Medicine, who presented an illustrated paper on "Indications for Cardiac Surgery."

Members of the Alachua County Medical Society present as guests included Drs. William C. Thomas, Sr.; Henry S. Blank; James M. McClamroch; and John E. Maines, Jr., all of Gainesville. Aso present were Ernest R. Gibson, assistant managing director, and Norman J. Ulbright, acting supervisor, Bureau of Public Relations, Florida Medical Association, and who, during their visit, conferred with Dr. Richard C. Cumming, chairman of the county public relations committee, and Dr. Eugene G. Peek, Sr., chairman of the Association's Committee on Legislation and Public Policy.

Orange

At the regular February meeting of the Orange County Medical Society, Dr. William A. Walter, Director, Division of Venereal Disease, Florida State Board of Health, conducted a round-table discussion on the interpretation of serology tests and treatment of syphilis.

Among the guests present were seven members of the Seminole County Medical Society.

At the March meeting of the Society, Dr. Leon Unger, Associate Professor of Medicine, Northwestern University, spoke on bronchial asthma; and Dr. Robert Glover, Clinical Professor of Thoracic Surgery, Hahnemann Hospital and Temple University, presented an illustrated talk on surgery of the mitral valve for relief of mitral stenosis.

Palm Beach

Dr. Albert F. R. Andresen, Brooklyn, N. Y., clinical professor emeritus of the medical center, New York City College of Medicine, addressed the Palm Beach County Medical Society at its monthly meeting in February.

Pinellas

The series of medical public forums sponsored by the Pinellas County Medical Society in cooperation with the St. Petersburg Times was praised in a recent issue of The PR Doctor, issued by the A. M. A. Department of Public Relations. The project was also hailed by Editor and Publisher, weekly trade magazine.

Sarasota

Members of the Sarasota County Medical Society met with the Manatee County Medical Society in March to hear a talk on "The Follow Up Treatment of Coronary Thrombosis" by Dr. Theodore VanDellen, assistant professor of medicine and assistant dean of the Northwestern University Medical School.

Suwannee

The Suwannee County Medical Society, in conjunction with the Suwannee County Health Department, the Florida State Board of Health and the American Cancer Society presented the Third Annual Cancer Seminar in Live Oak March 20.

BOOKS RECEIVED

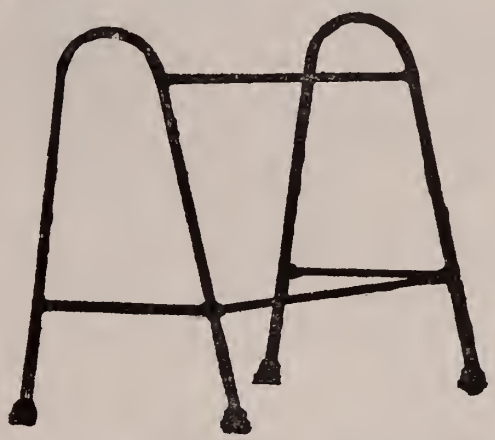
Standard Nomenclature of Diseases and Operations. Edited by Richard J. Plunkett, M.D., Editor, and Adaline C. Hayden, R.R.L., Associate Editor. Ed. 4. Pp. 1,034. Price, $8.00. Published for The American Medical Association. Philadelphia, The Blakiston Company, 1952.

This fourth edition of the standard guide to disease and operation recording for medical record librarians and physicians has been completely revised and brought up-to-date in keeping with medical progress. Sponsored by the American Medical Association, it is the result of three years of extensive work by an editorial advisory board and 21 committees representing each of the individual or specialty sections of the book.

Code numbers for acute and chronic conditions are made consistent, new heart diagnoses are included, diseases of the Hemic and Lymphatic systems are revised to conform to accepted terminology, the dental and tuberculosis sections are enlarged, and the section on operations includes new operative procedures used in skin grafts and cardiac surgery. Also, the supplementary terms are placed in one section and the disease and operations indexes are placed consecutively in the book.

In addition to these revisions, an International Statistical Classification of Diseases, Injuries and Causes of Death is included. These code numbers are cross-referenced to the "Standard" code numbers.

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Migraine In Children

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Vahlquist, B. and Hackzell, G.: Acta Paediatrica *38*: 622 (1949).

NO. OF CASES	SEX	AGE AT ONSET	CYCLIC VOMITING	DURATION OF ATTACK	INTENSITY
31	8 ♀ 23 ♂	3 yrs. (mean)	3 out of 31	2½ hrs.	severe in all cases

TABLE CONT'D

NO. OF CASES	UNILATERAL HEADACHE	NAUSEA	FLIMMER SCOTOMA	VERTIGO	HEREDITY
31	18 out of 31	31 out of 31	12 out of 31	6 out of 31	20 out of 31

(reference given above)

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*Katz, J., Friedman, A.P., and Gisolfi, A.: New York State J. Med. *50*: 2269 (Oct.) 1950.

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OBITUARIES

Henry Oscar Snow

Dr. Henry O. Snow of Tampa died at his home on Feb. 18, 1952. He was 75 years of age.

A native Floridian, Dr. Snow, the son of Henry O. and Sarah G. Snow, was born in Brooksville in 1876. He received his early education in Spartanburg, S. C., and the degree of Doctor of Medicine from the Atlanta College of Physicians and Surgeons in 1900. Since 1907 he had engaged in the practice of medicine in Tampa, specializing in surgery.

A veteran of the Spanish-American War, Dr. Snow served as a major in the Medical Corps during World War I. He was later assigned to the Public Health Service for Florida with headquarters in Tampa. He also served as Hillsborough County Physician. Locally, he was a member of the American Legion and the Palma Ceia Golf Club.

A Masonic leader, Dr. Snow was high priest, Tampa Chapter 3, Royal Arch Masons; past master, Tampa Council No. 8; past eminent commander, Tampa-Ivanhoe Commandery, Knights Templar; past grand high priest of the Royal Arch Masons of Florida; past most illustrious grand master of the Grand Council of Florida; past grand commander of the Grand Commandery, Knights Templar, Florida; past sovereign of St. Sebastian Conclave No. 27, Knights of Constantine; Knight of the York Rite Cross of Honor; member of Egypt Temple Nobles of the Mystic Shrine; past patron of Tampa Chapter No. 11, Order of the Eastern Star, and a past grand patron of the Grand Chapter of Florida, Order of the Eastern Star.

Dr. Snow was a member of the Hillsborough County Medical Association and the Florida Medical Association, of which he had been a life member for six years. He was also a member of the American Medical Association and the Southern Medical Association.

Surviving are the widow, Mrs. Douglas Snow, and a son, Oscar D. Snow, of Tampa; also four sisters, Mrs. Anna Davis of Tampa, Mrs. J. M. Spencer of Atlanta, Ga., Mrs. A. G. Evans of Monto Park, Calif., and Mrs. O. S. Nelson of Coral Gables; and three brothers, A. C. Snow of Pensacola, Proctor Snow of Dublin, Ga., and H. L. Snow of Cocoa.

Clarence M. Sandusky

Dr. Clarence M. Sandusky of Jacksonville died on Dec. 29, 1951 in Jefferson Hospital in Philadelphia after a brief illness. He was 74 years of age.

Born in Nicholasville, Ky., in 1877, Dr. Sandusky received his medical education in his native state. He was awarded the degree of Doctor of Medicine by the University of Louisville School of Medicine in 1902.

For a short time he engaged in the practice of medicine in Crescent City. He then located in Jacksonville, where he limited his practice to otorhinolaryngology and was physician for the Seaboard Air Line and Atlantic Coast Line railroads.

This prominent physician was also a financier of note and president of the Title and Trust Company of Florida. He enjoyed broad interests. An outstanding amateur horticulturist, he was a poineer in the raising of camellias. One camellia which originated in his gardens is named for his widow, Mrs. Margaret Sandusky, who alone survives him.

Dr. Sandusky was a member of the Duval County Medical Society. Since 1906 he had been a member of the Florida Medical Association, for the last 12 years a life member. He also held membership in the American Medical Association.

NOTICE

This May Journal carries the new officers and committeemen with the exception of the president-elect, vice presidents, secretary-treasurer and editor of The Journal. The names of these officers are omitted because the May Journal went to press before the election of officers by the House of Delegates, April 30.

All new officers will be listed in your June Journal, as will be the personnel of The Journal staff for 1952.

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting May 12, June 2, June 16. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting June 2, September 8. Surgical Anatomy & Clinical Surgery, Two Weeks, starting June 16, September 22. Surgery of Colon & Rectum, One Week, starting May 12, June 2. Gallbladder Surgery, Ten Hours, starting June 16. Basic Principles in General Surgery, Two Weeks, starting September 8. General Surgery, One Week, starting May 12, October 6. Breast & Thyroid Surgery, One Week, starting June 23. Esophageal Surgery, One Week, starting June 23. Thoracic Surgery, One Week, starting June 2. Fractures & Traumatic Surgery, Two Weeks, starting June 16.

GYNECOLOGY—Intensive Course, Two Weeks, starting June 16. Vaginal Approach to Pelvic Surgery, One Week, starting June 9, September 22.

OBSTETRICS—Intensive Course, Two Weeks, starting June 2, September 29.

PEDIATRICS—Informal Clinical Course every two weeks. Cerebral Palsy, Two Weeks, starting July 7.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting July 14. Gastroenterology, Two Weeks, starting May 19. Hematology, One Week, starting June 16. Gastroscopy & Gastroenterology, One Week Advanced Course, June 23.

CYSTOSCOPY—Ten Day Practical Course starting May 26, June 9, July 7.

DERMATOLOGY—Intensive Course, Two Weeks, starting October 13.

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NOTICE

Old officers and committee chairmen appear in this May Journal since it went to press before the election of officers at the annual meeting, April 28. New officers and committee chairmen will appear in your June Journal.

"Snake in the Grass"

If an alarm went out that there was a "snake in the grass," to a group of people in a certain field, a sudden caution would be exerted by those whose work kept them in that area. They would want to know, "Where?" and "What kind?" The snake in this case is turned loose in the field of medicine; its nature is sinister because it can damage those who are caught unaware; its species, propaganda.

On the Caduceus, which is the insignia of the physician, are two serpents wreathed around a staff, topped with wings; formerly it was identified with Mercury but which became the symbol of a great medical tradition. This symbol has

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*Lane, C. G., Therapeutic Dermatitis, New Eng. J. Med., 246:77-81, 1952
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been used by a modern author to the detriment of its real meaning in a book called "The Serpent-Wreathed Staff." In effect, the serpents have been released from the staff to slither among the grass roots of medicine causing regrettable confusion.

Whatever reason Mrs. Alice Tisdale Hobart had in the writing of this book she has succeeded in alarming the medical profession by her inaccurate treatment of a serious, national subject; she has pleased the proponents of compulsory health measures by the same action. This fact alone identifies the problem and emphasizes the continuing importance of being alert and informed so that we can intelligently counteract the false impressions a book of this type can create. It proves that our efforts in education are still of paramount importance. We must understand what we stand for in order to defend it as well as to interpret it to others. We lack the appeal of the romantic figure in that piece of fiction but we can help stabilize the resultant confusion with calm logical fact — if we acquire those facts.

This is our responsibility. Discover the source and nature of the threat; take steps to combat it, and be vigilant — for as in the parable of the weeds we are like the man who sowed good seed in his field; but while men were asleep, his enemy came and sowed weeds among the wheat and went away.

Mrs. C. Robert DeArmas.

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Dr. Wm. Dameshek, Tufts Medical College, Advances in Hematology.
Dr. D. C. Darrow, Yale University, Electrolyte Disturbances.
Dr. R. Elman, Washington University, Recent Advances in Surgery.
Dr. J. W. Hinton, New York University, Advances in Gastric Surgery.
Dr. J. B. Kirsner, University of Chicago, Gastrointestinal Diseases.
Dr. R. Levine, Michael Reese Hospital, Adreno-Cortical Steroids; also Recent Advances in Diabetes.
Dr. J. H. Means, Harvard University, Advances in Thyroidology and Clinical Applications.
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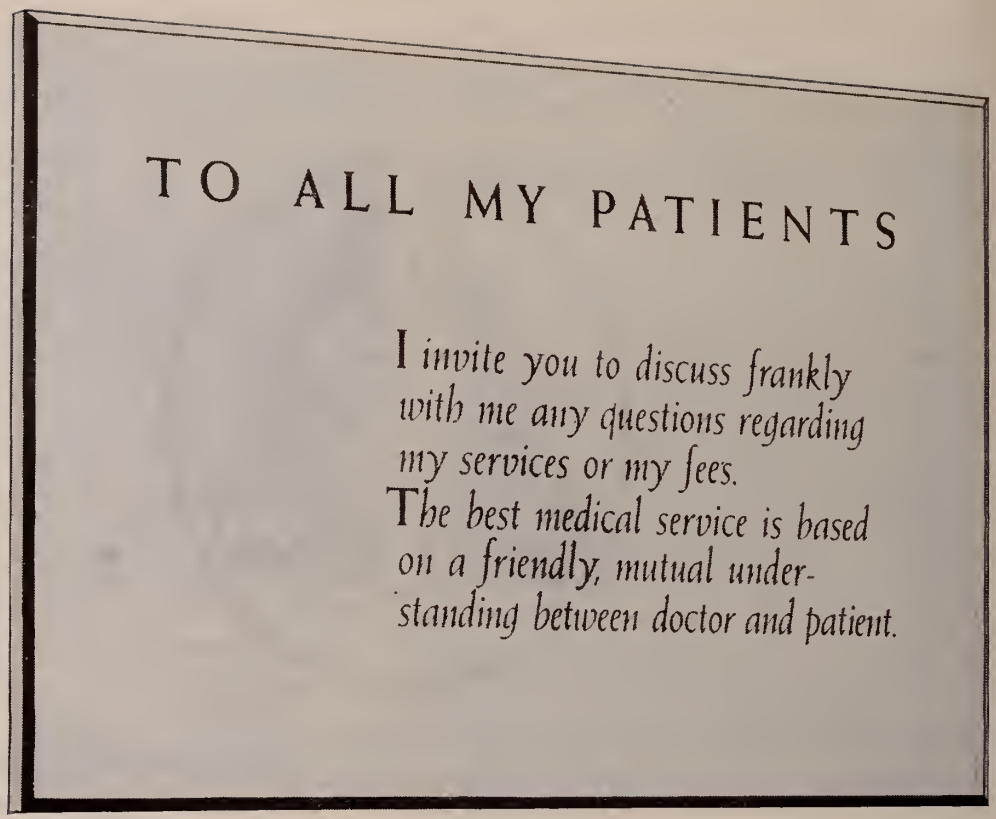
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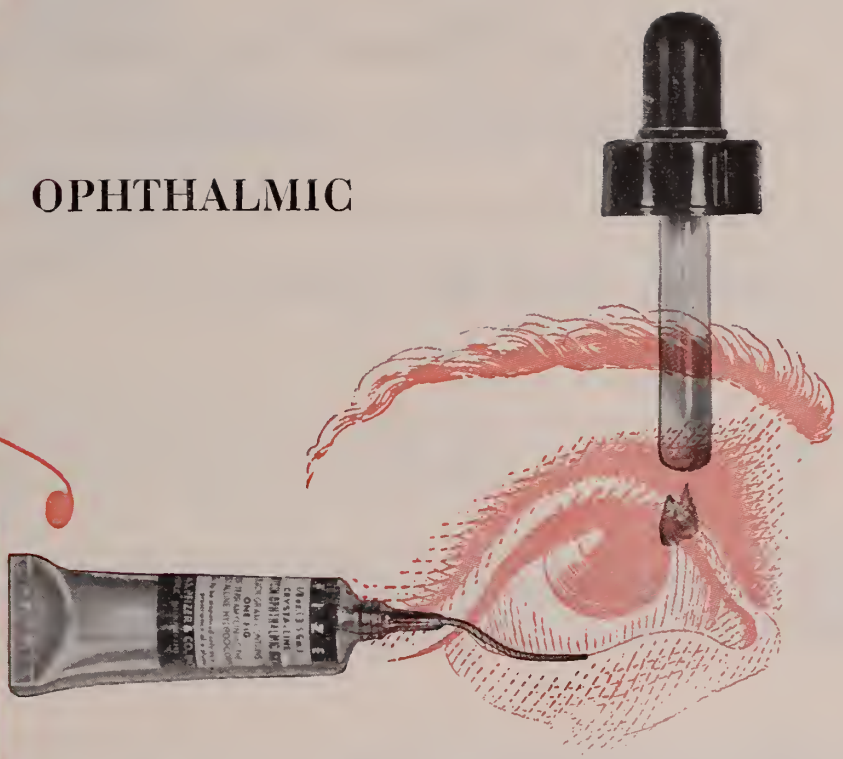
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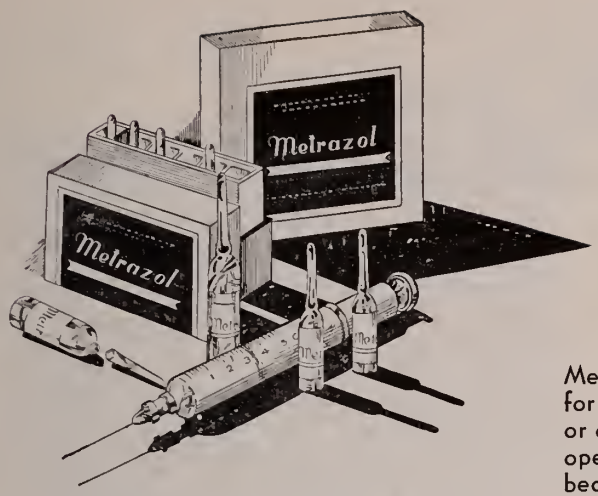


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orida Medical Association	David R. Murphey, Jr., Tampa	Samuel M. Day, Jacksonville	
orida Medical Districts	William C. Roberts, Panama City	Council Chairman	
A-Northwest	Arthur J. Butt, Pensacola	Benjamin A. Wilkinson, Tallahassee	Panama City, 1952
B-Northeast	Eugene G. Peek, Jr., Ocala	Eugene L. Jewett, Orlando	Daytona Beach, 1952
C-Southwest	Leldon W. Martin, Sebring	Hugh G. Reaves, Sarasota	St. Petersburg, 1952
D-Southeast	Adrian M. Sample, Ft. Pierce	Donald W. Smith, Miami	Ft. Pierce, 1952
orida Specialty Societies			
:ademy of General Practice	Elmer E. Leitner, Jacksonville	L. Paul Foster, Orlando	
lergy Society	George F. Hieber, St. Petersburg	James H. Putman, Miami	
iesthesiologists, Soc. of	Harold Carron, Tampa	Adelbert F. Schirmer, Orlando	
iapter, Am. Coll. Chest Phys.	Howard K. Edwards, Miami	Nathaniel M. Levin, Miami	
erm. and Syph., Soc. of	Rothwell Lefholz, Miami	Morris Waisman, Tampa	
ealth Officers' Society	Terry Bird, Apalachicola	Lorenzo L. Parks, Jacksonville	
eart Association	Elwyn Evans, Orlando	H. Milton Rogers, St. Petersburg	Miami, May 8-10, '52
dustrial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	
eurology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	
). and Gynec. Society	William C. Thomas, Sr., Gainesville	J. Champneys Taylor, Jacksonville	
phthal & Otol., Soc. of	Charles C. Grace, St. Augustine	Carl S. McLemore, Orlando	
thopedic Society	Francis W. Glenn, Miami	Edward W. Cullipher, Miami	
ciety of Pathologists	V. Marklin Johnson, W. Palm Bch.	Alfred E. Cronkite, Ft. Lauderdale	
diatric Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	
octologic Society	Charles E. Hebard, Tampa	George Williams, Jr., Miami	
adiological Society	John J. McGuire, Pensacola	Nelson T. Pearson, Miami	
ological Society	Lee Sharp, Pensacola	Frank M. Woods, Miami	
orida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 7, '52
Blood Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	Orlando, May 31-June 1, '52
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Daytona Beach, Nov. 16, '52
Blue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
Dental Society, State	John I. Todd, D.D.S., Jacksonville	Tom Price, D.D.S., Miami	
Hospital Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Beach, Nov. '52
Medical Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	Jacksonville, June 29-July 1, '52
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 23-28, '52
Nurses Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
Pharmaceutical Association, State	Mr. Euless Watford, Chipley	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-21, '52
Public Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct., '52
Tuberculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Basil E. Kenney, Sr., Pt. St. Joe	Daytona Beach, May 15-17, '52
Woman's Auxiliary	Mrs. C. R. DeArmas, Daytona Bch.	Mrs. J. V. McCall, Jr., Daytona Bch.	
nerican Medical Association	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Chicago, June 9-13, '52
A.M.A. Clinical Session	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
uthern Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, 1952
abama Medical Association	T. Brannon Hubbard, Montgomery	Douglas L. Cannon, Montgomery	
orgia, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	Atlanta, May 11-14, '52
E. Hospital Conference	Edwin B. Peel, Atlanta	Mr. R. G. Ramsey, Jr., Memphis	
utheastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath. B. MacInnis, Columbia, S. C.	
utheastern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Havana, Cuba, Mar. 26-29, '53
utheastern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
ulf Coast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct., '52

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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Total	MEMBERS Paid	COUNCILOR
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		24	21	
	Escambia *Santa Rosa*	Chas. J. Heinberg, M.D. 109 N. Baylen St. Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	74	64	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	William P. Blackmon, M.D. Apalachicola	Last Wednesday	8	7	
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	14	A-1-52 Arthur J. Butt, M.D. Pensacola
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	15	
	Washington-Holmes	George W. Carter, M.D. Chipley	Bayllye W. Dalton, M.D. Chipley		6	100%	
	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	12	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	58	52	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak		9	100%	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		4	3	
	Taylor *Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	1	234
B	Alachua *Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	49	47	
	Duval *Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	254	209	
	Marion *Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	28	16	B-3-52 Eugene G. Peek, Jr., M.D. Ocala
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	9	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	11	9	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	14	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	23	21	
	Lake *Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	26	23	
	Orange *Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	153	131	B-4-53 Eugene L. Jewett, M.D. Orlando
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	100%	
	Volusia *Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	81	77	666
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	174	144	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	19	16	
	Pasco-Hernando- Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	17	16	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	190	183	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	44	37	
	DeSoto-Hardee- Highlands- Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	27	23	
	Lee-Charlotte- Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	25	24	C-6-52 Leldon W. Martin, M.D. Sebring
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	91	79	587
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	5	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	117	113	D-7-52 Adrian M. Sample, M.D. Fort Pierce
	St. Lucie- Okeechobee- Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	7	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	84	70	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	594	442	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	James B. Parramore, M.D. Box 326	Herman K. Moore, M.D. 600 Elizabeth St.	2nd Thursday 8:00 P.M.	12	11	

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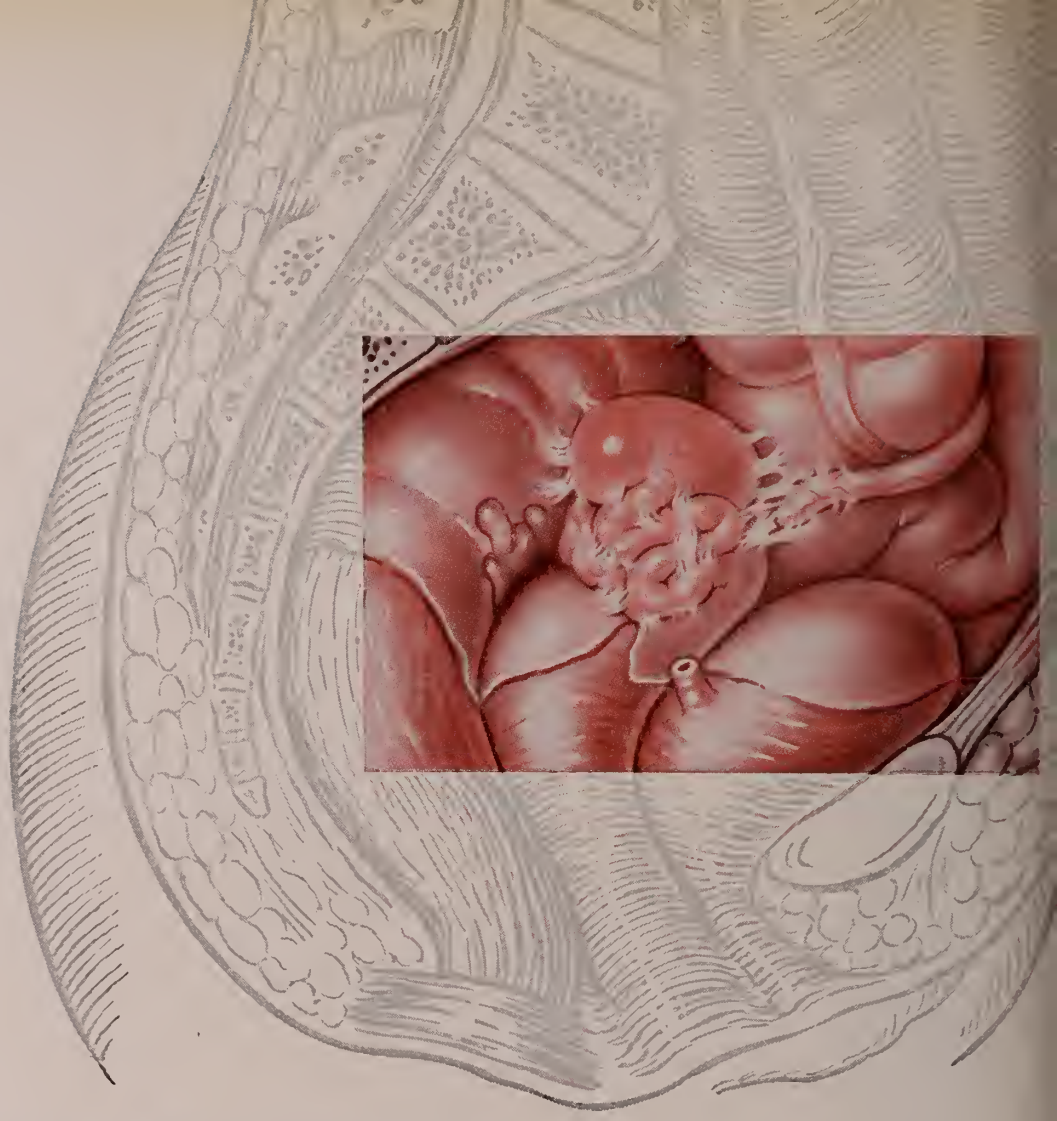
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David R. Murphey, Jr.

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1. Greene, G. G.: Kentucky M. J. *50*:8, 1952.
2. Stevenson, C. S., et al.: Am. J. Obst. & Gynec. *61*:498, 1951.

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Volume XXXVIII **JUNE, 1952** **No. 12**

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This Journal is not responsible for the opinions and statements of its contributors.

Published monthly at Jacksonville, Florida. Price $5.00 a year; single numbers, 50 cents. Address Journal of Florida Medical Association, P. O. Box 1018 (Fla. Theater Bldg.), Jacksonville 1, Fla. Telephone 6-1571. Accepted for mailing at special rate of postage provided for in Section 1103, Act of Congress of October 3, 1917; authorized October 16, 1918. Entered as second-class matter under Act of Congress of March 3, 1879, at the post office at Jacksonville, Florida, October 23, 1924.

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"therapeutic bile" overcomes stasis

what is "therapeutic bile"?

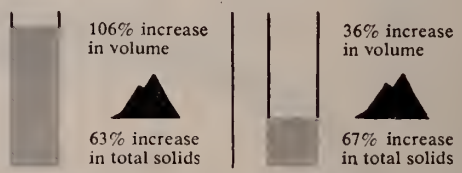
Thin, free-flowing bile in copious amounts as produced by *hydro*choleresis with *Decholin*.

what does "therapeutic bile" do?

Overcomes stasis in chronic cholecystitis and noncalculous cholangitis by flushing thickened bile, mucus plugs and debris from the biliary tract.

how does "therapeutic bile" differ from other bile?

"THERAPEUTIC BILE" is higher in fluid content and lower in solid content than bile produced by choleretics, e.g., ox bile salts.



*Hydro*choleretic: *Decholin*

Choleretic: Ox bile salts

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(brand of dehydrocholic acid)

how is "therapeutic bile" obtained?

"THERAPEUTIC BILE" is obtained by adequate dosage of *Decholin* and *Decholin Sodium*. Most patients require one or two tablets t.i.d. for four to six weeks. Prescription of 100 tablets is recommended for maximum efficacy and economy. More prompt and intensive *hydro*choleresis may be achieved by initiating therapy with *Decholin Sodium* 5 cc. to 10 cc. intravenously, once daily.

Decholin Tablets, 3¾ gr. (0.25 Gm.), bottles of 100, 500, 1000 and 5000.

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"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

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maleate

1. Silbert, N. E.: New England J. Med. *242*:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet *70*:26. 1950.

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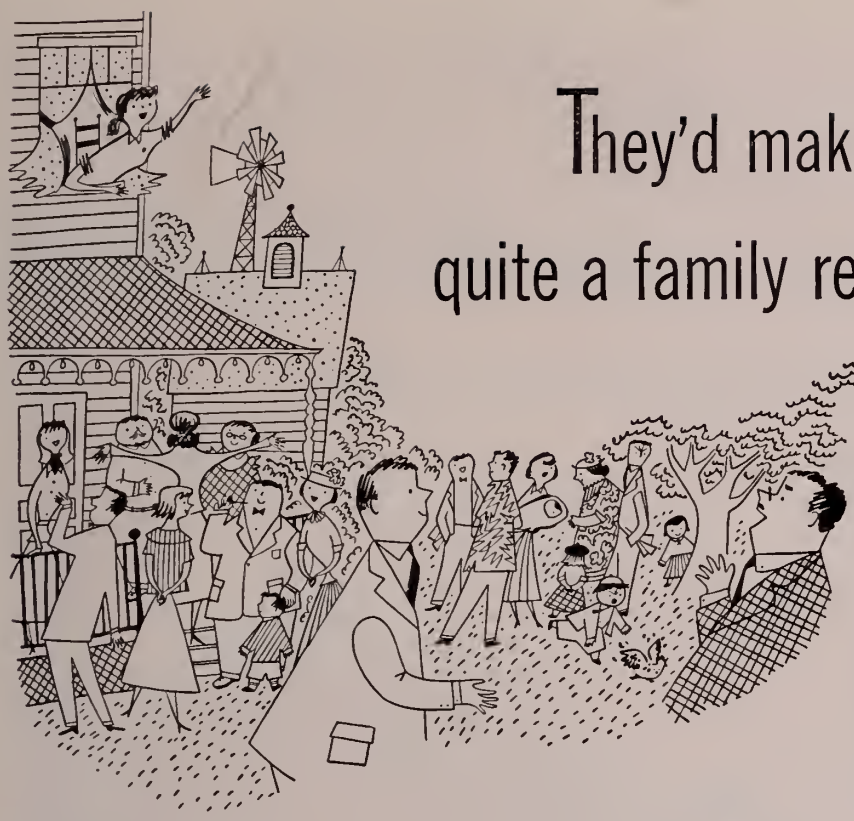
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To combat stimulation of ephedrine alone, etc.

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Hysteria
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Tetanus
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PEDIATRIC Sedation for:
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in ocular infections



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Many infections peculiar to the ocular structures, as well as those associated with systemic infection, may respond quickly to Terramycin despite previous resistance to other agents.[1,2]

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Often indicated in treatment of primary or secondary ocular infections such as *blepharitis, conjunctivitis, dacryocystitis, serpent ulcer of the cornea, hordeola, keratitis, trachoma, and keratoconjunctivitis.*

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Well-tolerated convenient preparations:

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Terramycin Oral Drops, concentrated dosage form for infants: 200 mg. per cc.
Terramycin Elixir, 250 mg. per teaspoonful.

1. Mitsui, Y., et al.: Antibiotics & Chemotherapy 1:253 (July) 1951.
2. Mitsui, Y., and Tanaka, C.: Antibiotics & Chemotherapy 1:146 (May) 1951.

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FOR THE PEPTIC ULCER PATIENT

"DOUBLE-GEL ACTION" **AMPHOJEL**



relieves pain promptly — stops gastric corrosion

promotes rapid healing — provides a soothing protective coating over the ulcer

no kidney damage — imposes no added burden on kidney function

never causes alkalosis — buffers gastric contents moderately; permits normal neutralization of alkaline secretions of upper intestine

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pleasant to take — smooth, creamy, pleasing taste and texture

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SUPPLIED: Liquid, bottles of 12 fl. oz. Also available: Tablets of 5 grains and 10 grains

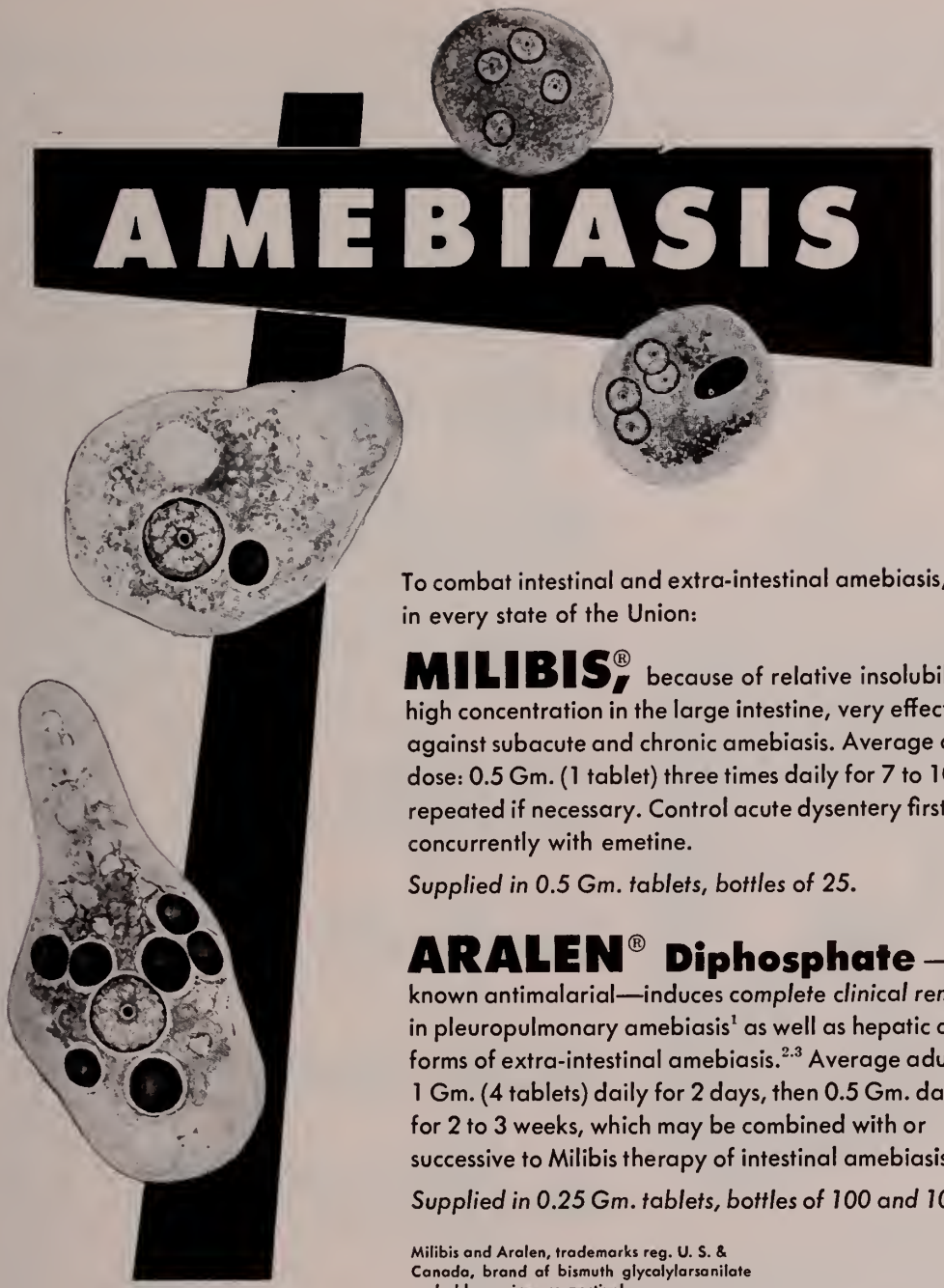
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MILIBIS,® because of relative insolubility, assures high concentration in the large intestine, very effective against subacute and chronic amebiasis. Average adult dose: 0.5 Gm. (1 tablet) three times daily for 7 to 10 days, repeated if necessary. Control acute dysentery first or concurrently with emetine.

Supplied in 0.5 Gm. tablets, bottles of 25.

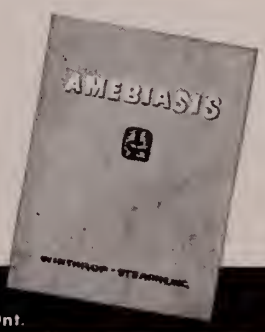
ARALEN® Diphosphate —the well known antimalarial—induces *complete clinical remission* in pleuropulmonary amebiasis[1] as well as hepatic and other forms of extra-intestinal amebiasis.[2,3] Average adult dose: 1 Gm. (4 tablets) daily for 2 days, then 0.5 Gm. daily for 2 to 3 weeks, which may be combined with or successive to Milibis therapy of intestinal amebiasis.

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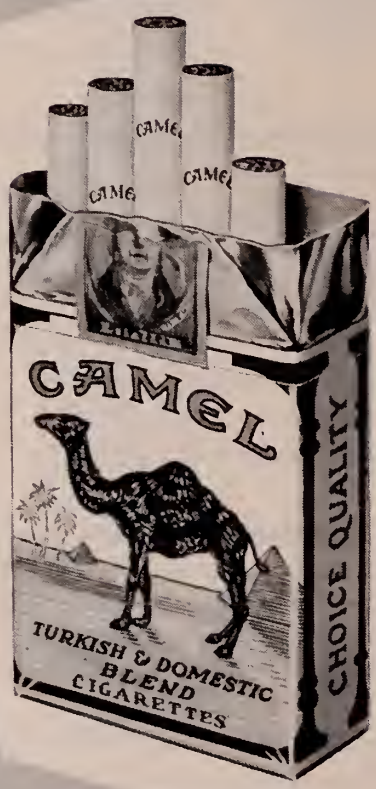
Milibis and Aralen, trademarks reg. U. S. & Canada, brand of bismuth glycolylarsanilate and chloraquine, respectively.

1. Lindsay, A. E., Gassard, W. H., and Chapman, J. S.: *Dis. Chest*, 20:533, Nov., 1951.
2. Conan, N. J., Jr.: *Am. Jour. Med.*, 6:309, Mar., 1949.
3. Emmett, J.: *J.A.M.A.*, 141:22, Sept. 3, 1949.

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*Gordon, Harry H.: Feeding of Premature Infants, American Journal of Diseases of Children 73:713 (June) 1947.

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Aureomycin in daily repeated small dosage gives satisfactory serum levels, and may be continued over a long period.

Aureomycin has been reported to be clinically effective against susceptible organisms in the following conditions frequently seen by the orthopedic surgeon:
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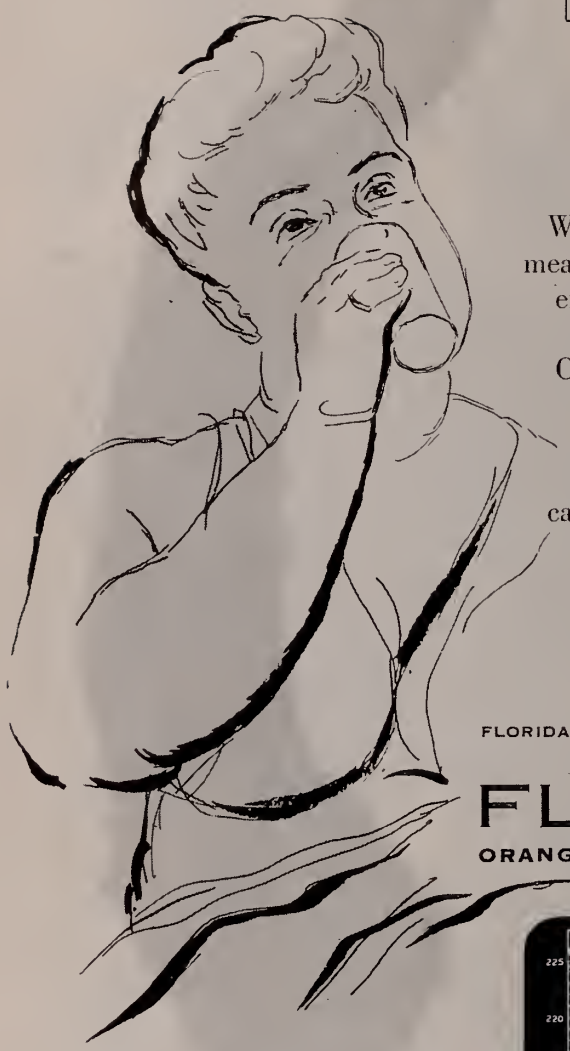
Throughout the world, as in the United States, aureomycin is recognized as a broad-spectrum antibiotic of established effectiveness.

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* *Postgrad. Med. 9:106, 1951.*

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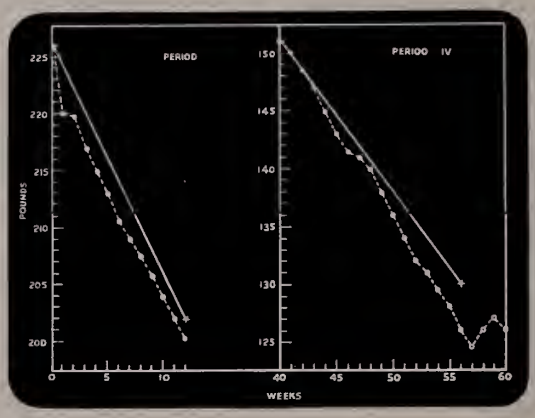


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Dr. Harris is a modest man. He may not even be aware that this is one reason why his patients have so much confidence in him. Another is his complete willingness to sacrifice his own comfort for their welfare. In his humility he has often said, "I just wasn't able to do as much as I wanted." In recent years, however, the odds in his struggle against disease and death have been immensely bettered by such powerful new weapons as the antibiotics. Penicillin, the first of these to be offered him by his ally, the pharmaceutical industry, was discovered by chance and nearly lost by an accident . . .

Lilly



. . . poured in the sink—almost!

Sir Alexander Fleming's discovery of penicillin nearly met with an accident which might have delayed the benefit of this product indefinitely. The unexpected growth of mold was almost dumped into the sink; it was saved only because of scientific curiosity.

Some time after Fleming's discovery, large-scale production was undertaken to meet the tremendous wartime needs for penicillin. Improvements which were developed in the Lilly Laboratories substantially increased the yield. More recently, a development in penicillin research has made it possible to treat in the office or home many patients who otherwise would require hospitalization. By eliminating the need for more frequent injections, this advancement has saved thousands of hours for physicians and their assistants.

In addition to seeking new products, Lilly research improves existing medicines in order to provide more efficient therapy.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXXVIII | Jacksonville, Florida, June, 1952 | No. 12

President's Address

David R. Murphey, Jr., M.D.
TAMPA

Mr. Vice President, Delegates, Members of the Florida Medical Association, and Guests:

Two years ago, at the annual meeting of this Association, you saw fit to bestow upon me your highest honor — the office of president-elect of the Florida Medical Association. I am deeply grateful for this honor, and also, for this expression of your confidence in me, as this office is not only honorary, but carries heavy responsibilities. One year ago when I was installed as your president, I promised to continue the administration of the affairs of this great medical association on its previous high plane, with all of my energy and to the best of my ability. This I have done. I trust that you will overlook my shortcomings, and will bear in mind that the errors I have made were in judgment and not in principle.

In Appreciation

In addition, when I was installed as your President, I appealed to each of you for your assistance and co-operation in our mutual task. This I have had beyond my greatest expectations. The Association is deeply indebted to the Board of Governors, and to the Chairmen and members of the various committees for their assistance in the accomplishments of the past year. It is easily understood, that by their very nature, some committees demand more of their Chairmen and members than others, and I would like at this time, on behalf of the membership for their faithful service, especially to thank the following committees: Advisory to Selective Service for Physicians and Allied Specialists, the Sub-committee on the Review of Fee Schedules, and the Committee on Legislation and Public Policy.

The outstanding scientific program of the Seventy-Eighth Annual Meeting prepared by Dr. James N. Patterson, and his Scientific Work Committee, is a permanent monument to the time and energy expended in its preparation. To them the Association is especially indebted. Last, but not least, the Chairman of the Public Relations Committee, Dr. Eugene B. Maxwell, his committee and the personnel of the State Public Relations Bureau, should be commended for their outstanding accomplishment in expanding the state public relations program.

The Board of Governors, at its January meeting, drafted Dr. Maxwell as Public Relations Chairman for the coming year. This action, unprecedented in the annals of the Association, very expressively recognizes his outstanding achievement during the year 1951-52.

It is unnecessary to call to your attention that these committees function year in and year out, at their own expense. Without their unselfish donation of time and money, the Florida Medical Association could not carry its broad scope of activities on its current budget.

Woman's Auxiliary

I am certain the membership does not need to be reminded of the importance of the Woman's Auxiliary to the Florida Medical Association in many of its activities both on a state and county level. The response of the Hillsborough County Woman's Auxiliary in assisting in the operation of the Association's first exhibit at the State Fair in February of this year, was most gratifying. The presence of these ladies in the Association booth created an atmosphere of friendliness and dignity in keeping with the ideals of the profession. On behalf of myself and the Association, I would like to commend this Auxiliary for a task well done.

In addition, I hope each doctor will encourage his wife to join the Auxiliary. I also urge those county societies which do not have an organized

Read before the Florida Medical Association, Seventy-Eighth Annual Meeting, Hollywood, April 29, 1952.

Woman's Auxiliary to assist your wives in establishing in your county this important adjunct to your local medical society.

Managing Director

Our Association is well organized, efficient and business like. This accomplishment is due largely to the genius and energy of our own Dr. Stewart G. Thompson. In 1926, Dr. Thompson became business manager of the Association, and since 1937 he has served as Managing Director and also as Managing Editor of the Journal. In 1947, the Association made plans for Dr. Thompson's retirement. Fortunately for the Florida Medical Association this plan provided a monthly stipend bginning at the age of 70, irrespective of his physical ability. In other words, our Managing Director was not forced to retire at a specified age. Dr. Thompson reached his seventieth birthday last year. Since then his services have been retained on a year to year basis. Such an arrangement secures for the Association his faithful, intelligent and experienced service at the same financial outlay as his retirement and replacement by a new, less experienced director. I sincerely hope that Dr. Thompson's health will permit, and that it will be his desire to continue in his present post for many more years, so that the future presidents will benefit by his wise, constructive counsel.

Dr. Thompson, I am deeply grateful for your assistance during my presidency.

Association Headquarters

For many years the advisability of relocating the office of the State Association has been informally discussed. This has been particularly true during the past year. There are two important factors to consider in the location of the State Association's office, namely, economy and efficiency of operation. Since it is not necessary for the efficient operation of the Association for any of the elected officers to reside in the same community as the state office, a local community derives no benefit from its location. On the other hand, the efficient operation of the state office is dependent on the accessibility of its location to other parts of the state. Florida is a large state, and its transportation system is not related to its geographic or population centers. For these reasons such a step, which involves the future welfare of the Association, should be carefully weighed and decided solely on merit and divorced from any other consideration.

Infantile Paralysis Foundation

Benevolence is, and always has been, an inherent characteristic of the nature of the American people, and a desire to help the less fortunate is constantly demonstrated on a national and international scale. This is particularly true in the field of health. As a result many lay groups have been organized for the purpose of controlling and treating specific ailments. The essential features of these organizations are the raising of funds through popular subscription and the subsequent disbursement of these funds for research and treatment of the specific malady. The success of the former, or fund raising element of the organization, is directly proportional to the emotional appeal to the American public. The ultimate success of these philanthropic organizations is entirely dependent on the co-operation and skill of the medical profession. Nevertheless, the medical profession is rarely consulted regarding the need for such an organization, or the method of its operation. Even less frequently is the profession recognized for its part in the success of these programs.

Such an organization is the National Foundation for Infantile Paralysis, Inc. This is a young organization. Beginning in 1932 as the Warm Springs Foundation, it became the National Foundation for Infantile Paralysis in 1938. The affliction of the late President Roosevelt and its strong emotional appeal, combined with a crippled child as its symbol, assured its success in the fund raising drives. The victims of this dreaded disease have been cared for by individual members of our profession, often without compensation and never with any recognition, as far as the public is concerned, for their part in the success of the project.

This organization has definitely entered the practice of medicine in a limited field. It has at times interfered with the free choice of physicians by the patient and his family. It has had a tendency to pauperize every victim of this ailment, regardless of his financial status. In many instances treatment has been continued into the static stage of the disease. This is a typical example of a lay body entering the field of medicine without the assistance and guidance of the medical profession as an organization. As a result the inevitable has occurred, namely, a one time wealthy organization has found it difficult to carry out its function.

With the approval of the Board of Governors of the Florida Medical Association, a series of

conferences have been held throughout the year with the National and State officials of the National Foundation for Infantile Paralysis, Inc.

As a result of these conferences, an agreement has been reached, whereby, the medical profession of the State of Florida, both on a state and county level, will be asked to appoint Medical Advisory Committees to the Foundation Chapters. These committees will act in an advisory capacity on medical matters and as liasion between the Foundation and the profession.

For the first time in its history, the medical profession of Florida is in a position to officially supervise the care of the victims of poliomyelitis in the State. It is the feeling of the National Foundation for Infantile Paralysis, Inc., and the officers of the Florida Medical Association, that this agreement will be of mutual benefit to both organizations. The ultimate beneficiary from this agreement will be the unfortunate victim of poliomyelitis.

Medical Progress

One hundred and five years ago, the American Medical Association was founded for the purpose of improving the health of the American people. To accomplish its aim, medical education, which at that time was in a chaotic condition, first had to be improved. For the first 70 years of its existence, elevating the standards of medical education in the United States was one of its major objectives. Through the sole efforts of the American Medical Association and without the assistance of the Federal Government, the year 1952 finds in our country the highest standards of medical education the world has ever known. This statement is substantiated by the results of a recent survey, sponsored by the World Medical Association among the medical profession of forty countries, which revealed the United States to be the country of choice for postgraduate and specialty training.

Since 1900 the quality of the graduates from our medical schools has steadily risen. These men have been privileged to practice their art in an atmosphere of individual and scientific freedom, unhampered by government control. This has resulted in a healthier, more long lived nation. During this half century 20 years have been added to the life span of the American people. The general death rate has been cut almost in half, resulting in the saving of a million American lives each year. The population of our country has doubled since 1900, but the population over 65 years of age during this same period of time has quadrupled. The infants, children and young adults whose lives were saved 30 to 40 years ago brought this about. In 1950, an expectant American woman faced a minimal risk, in that she had less than one chance in one thousand of failing to survive childbirth safely. This is the best maternal mortality rate in the history of our nation. The ten year period, 1940 to 1950, saw the infant mortality rate drop 38 percent. A baby born in 1952 has a 20 percent greater chance of reaching maturity, and a 44 percent greater chance of surviving to the age of 50, than an infant born in 1900, and at the same time, he has less than 50 percent chance of becoming an orphan before reaching maturity than if he had been born at the turn of the century.

Threat of Government Control

In spite of these accomplishments, the administration now in power continues to deplore the state of the nation's health and to advocate Federal medicine. The rejection rate of inductees into the Army in World War II is repeatedly used as justification for such a change. It is well known, to those sufficiently interested to investigate, that many of the rejections classified as medical were not on a physical basis. This fact the would-be-socializers have not seen fit to mention. Neither have they recognized that many of those rejected for physical reasons would have died in infancy, childhood, or early manhood, without the skill of modern medicine. These government figures, if properly analyzed and interpreted, are in reality proof of the effectiveness of the medical care rendered the American people during the past half century.

Our profession, unhampered by government interference saved the lives of many of those rejected for truly physical reasons, who in civilian life were good, self-supporting American citizens but unfit for the rigors of military duty. Could it be that the Administration desires a system of medicine that only preserves the lives of those that survive a disease without a disability?

With these facts and figures in mind, it is hard to see the necessity for defending our system of medical practice. Nevertheless, for the past 20 years, the medical profession has found itself under constant attack by a socialistically inclined Federal Government. During this period, millions of tax dollars have been spent by various agencies and bureaus to confuse the American people regarding the health of the nation. It would be a dese-

cration of our heritage from our medical predecessors not to defend our system of medicine.

Medical Public Relations

To meet this challenge and counteract the adverse propaganda, the profession on a national, state and county level has enlarged its public relations activities. A few years ago our State was the first to face a political campaign in which the issue of socialized medicine was so clearly drawn. It is conceded by both sides in this political campaign, those elected and those defeated, that the medical profession played a deciding role in the outcome of this issue. The decisive victory in Florida was duplicated within a few months throughout our nation. This was, unfortunately, not a final victory and our opponents remain just as determined to engulf our country with the same philosophy of government that has wrecked the British Empire.

It is the obligation of our profession, which originally organized for the purpose of improving the health of our people and which developed a system of medical care that has made this the healthiest large nation in the world, to preserve a free unhampered medical profession. Our defense is the story of American medicine; our offense, a well rounded public relations program.

It would be difficult for our professional predecessors of 50 to 75 years ago to comprehend the need of a public relations program. Certainly they needed no such program. At the turn of the century a physician was one of the most respected men in the community; he earned it. He delivered the baby, and was the pediatrician who guided him through childhood. He was the family psychiatrist and reassured a frustrated menopausal mother that her adolescent offspring would develop into a substantial American citizen. He was called for all family ailments. Grandfather's gout, coronary thrombosis, or prostatic obstruction were his problems. He was the family physician. What he lacked in scientific knowledge was partially compensated for in love for his fellowmen and good old common "horse sense."

Times have changed. Improved transportation has seen the general store of the village replaced by its urban competitors. This change the rural communities have accepted. Likewise rural and small communities have seen a migration of the medical profession to the larger communities where hospital and diagnostic facilities are available. This change they are loathe to accept, even though medical care is closer in lapsed time than it was in 1900.

The physician has acquired more scientific knowledge, but in some instances, he has lost his compassion. In some areas of the country the family has a different doctor for each illness, each organ or each segment of the body. In some communities the fees charged are often not related to the ability of the patient to pay, or are out of all proportion to the service rendered. At times an acutely ill patient is given an appointment for next week, or if the call is made at night he is told to come to the office in the morning. Unfortunately, each community has in its medical profession a few such practitioners. Otherwise, a county public realtions program would be superfluous. The State of Florida is no exception.

County Level Public Relations

The major function of a county public relations program is to educate those of its own physicians who are not cognizant of the ideals of our profession, and are not aware of the duty of a physician to his patient. When every patient in every community feels he is promptly and scientifically treated and at a reasonable fee, our problem will be solved. The State Association and all of the component county societies have organized grievance committees whose function is to hear the complaints of the laity against our members. These committees are extremely important in improving our relationship with the patient. Throughout the past year, these committees have functioned well.

The day has long since passed when every physician was not only the competitor, but the avowed enemy, of his local colleague. The public will not have unshakeable confidence in the profession unless it has that confidence in its individual members. A shrug of the shoulders, a smile, and often silence, are more effective than a disparaging remark about a fellow practitioner in shaking individual confidence in one's colleague. It is the responsibility of the county medical society to develop the proper intraprofessional relationship among its members.

The practice of medicine is interesting, although an exacting and fatiguing profession. It is essential that its members, like all individuals engaged in trying physical and mental occupations, indulge in periods of complete relaxation in order to meet their responsibilities efficiently. These breaks in practice should be arranged so that the community is never without adequate medical care. Many of our colleagues in the smaller communities of the

State alternate time off. Most of the cities in the State have emergency medical call services. It is the obligation of the county medical society to see that medical care is always available to the citizens of the area. This is an important factor in a county public relations program.

A county medical society must have an official spokesman in matters of public interest pertaining to local health matters. The official voice of the county society should be the public relations committee. A co-operative public relations committee at the county level can make many friends for a local medical group. It behooves the component county societies to create in the minds of their local communities the feeling that the medical profession, as an organization, is its friend and fundamentally interested in its health and health problems. There are many and varied ways of accomplishing this objective, among which are: press releases, radio, television, public forums and physician speakers to lay groups of all types and classes.

Public Relations Bureau

The Florida Medical Association for many years has maintained a Public Relations Bureau. The Bureau has always been available to the component county societies for assistance and advice in organizing and operating a county public relations program. The State Association does not subsidize, directly or indirectly, a county public relations program. In order to carry the story of American Medicine to the entire population of the State, it is necessary to supplement the existing county public relations program on a State level. The Florida Medical Association has gradually, through the years, increased its activities in this field.

State Fair Exhibit

Two additions were made to the activities of the State Public Relations program in 1951-52 — a fair exhibit and a rural health education program. The former was the first medical exhibit to be presented at a fair in the history of the Florida Medical Association. This was shown at the Florida State Fair, in Tampa, Feb. 5-16, 1952.

The display compared the cost of health and expenditures for pleasure by the American people for the year 1949 in a manner easily understood by any of the one million plus people who passed through the turnstiles of the exposition. In keeping with the dignity of its sponsor, the Florida Medical Association, the exhibit combined color, motion and comedy to attract attention. In addition, we endeavored with cartoons to answer some of the questions pertaining to medical care in the minds of the laity. Even more than met the eye, the exhibit was used to render a real service to its patrons, with complimentary blood typing and taking blood pressure.

The cost, accuracy and feasibility of mass blood typing in case of disaster was determined and the data thus obtained presented to the State's civil defense program.

Blood pressures were taken by student nurses of two of the training schools in the area. This gave these schools an opportunity to contact prospective students under the most favorable circumstances.

It is difficult to determine the effectiveness of any public relations project. Each of the 11,470 persons securing a service at the booth was given medical literature obtained from the American Medical Association and bearing the stamp of the Florida Medical Association. Repeated checks of the fair grounds, which were littered with discarded leaflets of all types, failed to reveal any secured at the Association's booth. We feel that this is evidence of the appreciation and good will of our patrons.

The State Association was honored by the presence of Mr. Larry Rember, Field Service Director of the American Medical Association, Department of Public Relations, who visited our exhibit for several days during its operation. The purpose of his visit was to study the exhibit with particular reference to its design, operation and effectiveness. The Tampa Tribune on Feb. 17, 1952, quoted Mr. Rember's reaction to the exhibit as follows: "We think this is the most outstanding exhibit of its type that has been presented anywhere in the country."

Time does not permit a detailed description of the exhibit, or its organization. This exhibit is featured in the booth of the Florida Medical Association, Public Relations Bureau, now on display in the exhibit hall. The staff of the State Public Relations office will be only too glad to explain it in its entirety.

Rural Educational Program

The second addition to the State program is the rural health education program. This program was developed after conferences with officials of

the American Medical Association, and the two State Universities, the University of Florida, and the Florida State University. The Florida Agricultural Extension Service of the University of Florida, with its seventy-four county agents and the Home Demonstration Division of the Florida State University, with its fifty-nine home demonstration agents, are anxious to obtain health material for distribution to the rural population.

The Florida Medical Association has agreed to co-operate in this program to the following extent:

(1) Speakers
   a. Any disease or health topic.
   b. Community health problems.
   c. The importance of voluntary health insurance.

(2) Furnish
   a. Health films by the American Medical Association, through the Florida Medical Association.
   b. Health literature, approved by the American Medical Association and the Florida Medical Association.
   c. American Medical Association exhibits on heart, cancer, botulism, etc.
   d. Transcribed radio programs on health, American Medical Association produced.

(3) Unanticipated services or materials upon request, after approval of the State Public Relations Committee, Florida Medical Association.

During the past year, 19,430 pieces of literature have been distributed by this method. This program is in its infancy, and is in the process of development. Its success will depend on the co-operation of the component county medical societies and of our individual members. This can be a valuable addition to our public relations program in that it gives the Association access to a large group of people not previously reached, and without materially increasing the expense of the Bureau.

The 1950 National census revealed the State of Florida to have a total population of 2,771,305. Of these, 957,415, or 34.5 percent resided in communities of less than 2,500 population, and are properly classified as rural. In other words, one-third of our population are potential beneficiaries of this project.

Recommendations

The importance of an active public relations program to the medical profession of the State is obvious. A few of our counties have outstanding programs in operation. Some of our counties have public relations committees which have been inactive, and many of our counties have no program at all. I would like to recommend and urge each component county medical society to organize a public relations program. The State Public Relations office is ready and willing to advise and assist in its development. It should be unnecessary to warn against adopting a program beyond your physical and financial ability to carry to successful completion.

Second, I would like to recommend that the State Public Relations Program be continued on a state-wide basis, properly staffed and adequately financed and that individual members actively participate when called upon.

Voluntary Health Insurance

The past year has seen a continued increase in the number of participants in voluntary prepaid hospital and medical care plans. The Blue Cross and Blue Shield, sponsored by the medical profession, pioneered this type of insurance. Subsequently this field of insurance has been entered by commercial companies, and a competitive voluntary health insurance developed, resulting in better coverage and lower costs.

In developing this field of insurance, Blue Shield and Blue Cross, served its most important function. This was an important contribution in our fight against compulsory federal health insurance. As originally designed, voluntary health insurance was for catastrophic illnesses, and it has largely developed into a surgical plan. Catastrophic illness is not limited to diseases requiring operative therapy. Blue Shield can again serve in a pioneering manner by broadening its coverage into other fields of medicine. There is sufficient statistical material available from its previous experience in health insurance to permit accurate estimates of the cost of such expansion. One of the big difficulties experienced by companies engaged in this field of insurance is exploitation by a few of its policy holders and by a few of its participating physicians. A deductible type of policy might well be the answer to the question of how

to protect voluntary health insurance against some of the hazards of exploitation. I would like to recommend to the Directors of Florida Blue Shield and Blue Cross that they carefully study the feasibility of broadening the coverage of the plan, so that the entire field of medicine is covered for the policy holder.

My Auxiliary

I have sincerely enjoyed the privilege of being a member of the medical profession and even more, the opportunity of serving this noble profession in an official capacity. This pleasure has more than compensated me for the time and energy consumed in carrying out my official obligations. I am certain the past two years, first as president-elect, and then as president, have been equally as difficult for my auxiliary, Caroline. She has spent many a lonely night or week-end as a result of my official duties. In addition, it has fallen her lot to entertain often without notice, both National and State dignitaries. She has been my auxiliary in every sense of the word. She has not failed me. I would like at this time to publicly recognize her.

ABSTRACTS OF MEDICAL ARTICLES

The Future in Gynecology. By J. Randolph Perdue, M.D. South. M. J. 45:77-79 (Jan.) 1952.

After reviewing the milestones of progress leading to modern gynecology, Dr. Perdue notes the shift in the last quarter of a century to approaches other than surgical, including endocrinology, progress in obstetric care, proper handling of the psychosomatic patient and education both of the physician and the patient.

In his chairman's address before the Section on Gynecology at the forty-fifth annual meeting of the Southern Medical Association, he predicts for the future a decline of the surgical phase of the specialty, virtual disappearance of the supravaginal hysterectomy, closer professional scrutiny of proposed pelvic surgery in hospitals, decreased incidence of carcinoma of the uterus through cytology, continued solution by endocrinology of problems now considered surgical, antibiotic advances of the ultra viruses and beyond, more precise methods of diagnosis of the solid or semisolid ovarian tumor, continued expansion of public knowledge of gynecology and continued increase in the number of qualified gynecologists. Ultimately, he visualizes a 40 per cent reduction in the number of necessary pelvic operations on women, and much more than 40 per cent increase in "health and happiness" salvage from the efforts of members of this specialty.

Red Blood Cell Suspension Transfusions. By Donald W. Smith, M.D., and John Elliott, Sc.D. J. A. M. A. 147:737-740 (Oct. 20) 1951.

The authors urge more specific use of the major components, cells and plasma, for greater therapeutic benefit to the patient and economy for the blood banks.

The principal indications mentioned for cell suspension transfusions are the anemias unaccompanied by diminution of blood volume or by severe hypoproteinemia and for transfusions in which a sudden increase in blood volume is contraindicated such as in heart disease.

Blood plasma is recommended for the restoration of blood volume as in shock from burns and trauma, and as emergency treatment of shock from hemorrhage when whole blood is not yet available.

A simple method of calculating the amount of blood or cell suspension required is presented. This is based upon the actual circulating deficit as determined by hemoglobin determination or erythrocyte count correlated with the patient's estimated standard blood volume, which the authors accept as 40 cc. per pound body weight in normal health. Example: 100 pound patient with 50 per cent hemoglobin or 2.5 million red blood cell count would require $40 \times 100 \times 0.50 = 2{,}000$ cc.

PROCEEDINGS
Seventy-Eighth Annual Meeting

of the

FLORIDA MEDICAL ASSOCIATION
HELD AT HOLLYWOOD
APRIL 28, 29, and 30, 1952

GENERAL SESSIONS

First General Session

The Seventy-Eighth Annual Meeting of the Florida Medical Association was called to order at 9:30 a.m., Monday, April 28, in the Sun Room of the Hollywood Beach Hotel, Hollywood, by President David R. Murphey, Jr.

Invocation was pronounced by The Reverend Harold C. Williamson, Pastor, St. John's Episcopal Church, Hollywood.

President Murphey: "Dr. Ralph S. Sappenfield, President of the Dade County Medical Association, will give the address of welcome."

Dr. Sappenfield: "Dr. Murphey, friends, it is with great pleasure that I, as President of the Dade County Medical Association, act as your Grover Whalen to welcome you to Hollywood for the seventy-eighth annual session of the Florida Medical Association.

"Let us be mindful of our responsibilities to our colleagues who have gone before us, who have pioneered public relations and who have won for us a place in the hearts of our people, which is envied by all professions.

"A recent survey which has been quoted by the legal profession in many articles and talks, reveals the most sought-after group in time of trouble, is the medical profession, and second, the clergy. This position, as well as the freedom of our profession, should it die, could die of neglect by slow decay, by indifference. It is unthinkable that the American physician who personally forged this new concept, should ever abandon his role for want of passing indifference. Action can take many forms and one of the most vital is that of individual participation in our activities; and second, for our various units of organization to take a positive, decisive stand upon current issues; and thirdly, these should be led by a strong state organization, geared for swift and positive action.

"Again, we welcome you, and may this meeting be unified in purpose, with the will to do and the determination and leadership to see it through."

There being no further business the meeting adjourned on motion, duly seconded, at 9:50 a.m.

Second General Session

The Second General Session of the Florida Medical Association convened at 11:30 a.m., Tuesday, April 29, in the Sun Room of the Hollywood Beach Hotel, Hollywood; President Murphey in the Chair.

President Murphey: "The Second General Session will now come to order."

President Murphey: "Members of the Florida Medical Association and guests: For years the President of the Florida Medical Association has enjoyed the privilege of selecting the guest speaker for the annual meeting. Some of the outstanding physicians and surgeons of the country have contributed their time and knowledge to the success of our programs. I am certain that each of my predecessors has introduced the guest speaker to this assembly with a feeling of pride and personal admiration for his scientific accomplishments.

"In presenting the guest speaker to the Seventy-Eighth Annual Meeting of the Florida Medical Association it is with a feeling of not only admiration, but of deep gratitude. In 1945 it was my misfortune, while serving in the Armed Forces, to suffer an injury that was not only painful, but progressively incapacitating. In 1949 it was my good fortune to undergo definitive surgery at his hands.

"My remarkable recovery and presence here today are indicative of his surgical skill. I am certain that as a result of my brief association with him, as a patient, I have a deeper personal understanding of the human side, or Art of Medicine. He is truly a physician.

"In my hospital room were three books, furnished by the hospital — the Bible and two volumes devoted to the history of the Massachusetts General Hospital. As soon as I had recovered sufficiently to feel that it was safe to put the Bible aside, being interested in the organization of hospitals and hospital staffs, I spent considerable time reading the history of this outstanding medical institution.

"One of the rules of this institution is that a scientific paper cannot be presented without staff approval. The minutes of one of the staff meetings of 1931 or 1932, revealed that our guest speaker requested permission to present to the New England Medical Association, two cases with cord symptoms from pressure by protruding intervertebral cartilage, each of which were relieved by removing the offending cartilage. These minutes further revealed that permission to present this paper was denied, as the subject was not of sufficient general medical interest. These two cases represent the first successfully treated ruptured disks in which the etiology was recognized.

"Following this astute observation, the surgical literature became filled with treatises on this subject. As one would expect, enthusiasm in many instances replaced sound surgical judgment, and poor results were frequent. Throughout this period the discoverer of this syndrome remained the same quiet, unassuming, keen clinician, an attitude that has been reflected in his clinical results.

"It was my recent privilege to have lunch with one of our speaker's contemporaries, a professor of surgery of one of the other Boston institutions. When he learned that I had been operated upon for a cervical disk, he was amazed at the result until I told him the surgeon. His remark, 'You were operated on by Mr. Disk,' is a brief summation of his standing at home and abroad.

"Our distinguished guest, the son of an outstanding Boston surgeon, graduated from the Massachusetts Institute of Technology in 1902, and from Harvard Medical School in 1906. He was House pupil at the Massachusetts General Hospital, prior to the days of interns and residents. Some five or six years following his appointment to the Staff of the Massachusetts General Hospital, he decided to make neurosurgery his major interest, and studied under Sir Victor Horsley of London.

"Our guest served with the Harvard Unit in France during World War I, prior to the entrance of our country into the conflict. When war was declared, he returned to France with the Massachusetts General Hospital Unit, was stationed at Bordeaux, later in England, and was discharged from the Army as a Lieutenant Colonel.

"In the early '30's the Massachusetts General Hospital established its Neurosurgical Service, and he was appointed Chief of this Division. He continued in this capacity until just before the entrance of the United States into World War II, when he was retired on the Emeritus list. This retirement was brief, however, as he was recalled for active service, and served as Senior Civilian Consultant in Neurosurgery to the Surgeon General's Office, in Washington. He is at present serving in the Veterans Administration Hospitals in this same capacity.

"He is a member of the Corporation of the Massachusetts Institute of Technology, and a Trustee of the Massachusetts General Hospital. He is the immediate past president of the New England Surgical Association.

"It is with admiration and deep esteem that I present Dr. William Jason Mixter, of Boston."

Address: "Pitfalls in the Surgery of the Intervertebral Disk," by Dr. Mixter.

President Murphey: "Dr. Mixter, as President of the Florida Medical Association, and probably your most grateful patient, we want to thank you for a most delightful address."

President Murphey: "The Reference Committees will meet this afternoon at 2:30 to consider resolutions and annual reports referred to them by the House of Delegates at its first meeting. Members of the Association who wish to be heard on part of the material that Reference Committees will consider are urged to be present. Your counsel and suggestions may contribute valuable information to aid the Reference Committees."

There being no further business, the second general session adjourned at 12:40 p.m.

HOUSE OF DELEGATES

First House of Delegates

The House of Delegates convened at 9:30 a.m., Tuesday, April 29, 1952 in the Sun Room of the Hollywood Beach Hotel, Hollywood, with Dr. David R. Murphey, Jr., President, in the Chair.

Dr. Louis M. Orr, II, chairman of the Credentials Committee, was recognized and reported 102 delegates whose credentials were in order.

The Chair declared a quorum to be present.

Dr. William M. Rowlett moved that the delegates be seated.

Motion seconded and carried.

At 11:00 a.m., Dr. Orr stated that as of that moment there were 113 duly registered delegates present.

Delegates

ALACHUA—J. Maxey Dell, Jr., James M. McClamroch
BAY—William C. Roberts
BREVARD—Thomas C. Kenaston
BROWARD—Russell B. Carson, M. Austin Lovejoy, Richard A. Mills, Leigh F. Robinson
COLUMBIA—*(Absent—Laurie J. Arnold, Jr.)*
DADE—Turner E. Cato, Jack Q. Cleveland, Reuben B. Chrisman, Jr., Edward W. Cullipher, DeWitt C. Daughtry, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Raymond L. Evans, Edward F. Fox, W. Tracy Haverfield, Ralph W. Jack, Walter C. Jones, Donald F. Marion, John D. Milton, Benjamin G. Oren, Frazier J. Payton, Homer L. Pearson, Jr., Kenneth Phillips, Warren W. Quillian, Walter W. Sackett, Jr. Ralph S. Sappenfield, George F. Schmitt, Jr., Donald W. Smith, Franz H. Stewart, Joseph S. Stewart, Arthur H. Weiland, Nelson Zivitz.
DeSOTO-HARDEE-HIGHLANDS-GLADES—Hubert W. Coleman
DUVAL—James L. Borland, Frederick H. Bowen, Turner Z. Cason, Frank L. Fort, A. Judson Graves, Karl B. Hanson, Edward Jelks, Raymond R. Killinger, Ferdinand Richards, C. Burling Roesch, W. W. Rogers, Walker Stamps
ESCAMBIA—Egbert V. Anderson, Herbert L. Bryans, George W. Morse, Walter C. Payne
FRANKLIN-GULF—Albert L. Ward
HILLSBOROUGH—Chas. W. Bartlett, Leffie M. Carlton, Jr., Herschel G. Cole, Joshua C. Dickinson, Samuel G. Hibbs, Eugene B. Maxwell, James N. Patterson, William M. Rowlett
INDIAN RIVER—Erasmus B. Hardee
JACKSON-CALHOUN—Daniel A. McKinnon
LAKE—*(Absent—C. McK. Tyre)*
LEE-CHARLOTTE-COLLIER-HENDRY—William H. Grace
LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON—Taylor W. Griffin, Francis T. Holland, William D. Rogers
MADISON—*(Absent—Candler K. Hayes)*
MANATEE—Millard P. Quillian
MARION—Eugene G. Peek, Jr.
MONROE—*(Absent—James B. Parramore)*
NASSAU—Benjamin F. Dickens
ORANGE—Carl D. Hoffman, Duncan T. McEwan, John D. McKey, Meredith Mallory, Sr., Louis M. Orr, II, Frank J. Pyle, Robert L. Tolle
PALM BEACH—V. Marklin Johnson, Graham W. King, Jr., David A. Newman, Cecil M. Peek, Vale D. Stone
PASCO-HERNANDO-CITRUS—*(Absent—William H. Walters, Jr.)*
PINELLAS—M. Eldridge Black, William M. Davis, Albert R. Frederick, Everett M. Harrison, Francis H. Langley, Alvin L. Mills, John P. Rowell *(Absent—N. Worth Gable)*
POLK—Jere W. Annis, James R. Boulware, Jr., Ivan W. Gessler, Marion W. Hester
PUTNAM—Lawrence G. Hebel
ST. JOHNS—Herbert E. White
ST. LUCIE-OKEECHOBEE-MARTIN—Richard F. Sinnott
SARASOTA—John M. Butcher, *(Absent—Hugh G. Reaves)*
SEMINOLE—Frank L. Quillman
SUWANNEE—John N. Sims, Sr.
TAYLOR—Walter J. Baker
VOLUSIA—C. Robert DeArmas, Achille A. Monaco, Joseph H. Rutter, Morris B. Seltzer
WALTON-OKALOOSA—Arthur G. Williams, Sr.
WASHINGTON-HOLMES—Bayllye W. Dalton
ASSOCIATION OFFICERS—David R. Murphey, Jr., Robert B. McIver, Frederick K. Herpel, Edward R. Annis, Samuel M. Day, Shaler Richardson. *(Absent—Chas. J. Collins)*

On motion by Dr. Herbert E. White, seconded by Dr. Edward Jelks, the minutes as published in the June 1951 Journal were approved.

President Murphey: "The Chair will now turn the gavel over to the first vice president, Dr. Frederick K. Herpel."

Dr. Herpel: "In accordance with our action at the last meeting of the House of Delegates, the time for the address of the President of the Association was changed to a meeting of the House of Delegates. It is therefore our pleasure now to hear a report of his stewardship, and an address by our President, Dr. David R. Murphey, Jr., of Tampa."

The membership stood in unison as President Murphey arose to present his address.

(The complete presidential address may be found in this Journal on pages 847-853.)

Dr. Herpel: "I think I voice for the members of the House of Delegates and others of us here our great appreciation for a most delightful, most comprehensive and most stirring report from our outgoing president. He is certainly to be congratulated. The type of leadership which has been evidenced by Dr. Murphey will be difficult to equal."

Dr. Murphey resumed the Chair.

President Murphey: "The Association is fortunate in having distinguished visitors which the Chair would like to recognize at this time. Will

the following visitors please stand and be recognized:

"Mr. Alfred J. Jackson, Director, State Journal Advertising Bureau, A. M. A., Chicago.

"Mr. C. P. Loranz, Secretary-Manager, Southern Medical Association, Birmingham, Ala.

Dr. David Henry Poer, Secretary-Treasurer, Medical Association of Georgia, and editor of their Journal."

Dr. Murphey: "We are fortunate to have with us one of our past guest speakers, a native of Tennessee, New York and Florida, who needs no introduction to this Association, Dr. Joseph E. J. King."

The Chair then recognized Mrs. C. Robert DeArmas, President of the Woman's Auxiliary to the Florida Medical Association; Mrs. Mason G. Lawson, Second Vice President of the Woman's Auxiliary to the American Medical Association; and Mrs. Virgil Eugene Holcombe, President of the Woman's Auxiliary to the Southern Medical Association.

The Chair stated that a point of order had been raised relative to the wording in the Handbook for Members of the House of Delegates on the election of a third member to the A. M. A. House of Delegates. The Chair ruled it in order to elect a third Delegate to the A. M. A. House of Delegates for the remainder of 1952 and for a two year term beginning Jan. 1, 1953, and to elect a third Alternate to the A. M. A. House of Delegates for the remainder of 1952 and for a two year term beginning Jan. 1, 1953.

The Chair called for nominations of a third Delegate to the A. M. A.

Dr. Walter C. Payne nominated Dr. Herbert L. Bryans of Pensacola.

Dr. Chas. W. Bartlett moved the nominations be closed, and the secretary cast the ballot for the election of Dr. Bryans.

Motion seconded and carried.

President Murphey: "The Chair will entertain nominations for an Alternate Delegate to the A. M. A. House of Delegates for the remaining months of 1952 and a two year term beginning Jan. 1, 1953."

Dr. Joseph S. Stewart: "I would like to place in nomination the name of Dr. Thomas H. Bates of Lake City."

Dr. Bartlett: "I move the nominations be closed, and the secretary cast the ballot for the election of Dr. Bates."

Motion seconded and carried.

President Murphey: "The next order of business is the election of a Delegate to the A. M. A. House of Delegates for a two year term beginning Jan. 1, 1953."

The Chair recognized Dr. Homer L. Pearson, Jr.

Dr. Pearson: "Before you receive the nominations, I should like to give the House of Delegates a little information. I am a member of the A. M. A. Judicial Council and sit in the House of Delegates without the privilege of voting. Dr. Orr and I have discussed this at length and we feel that the Florida Medical Association would better be served by having a member of the Judicial Council who is not a Delegate. I wish to ask that my name not be placed in nomination for election to the House of Delegates for the term beginning 1953, because in that way we can have four rather than three members who will sit in the House of Delegates. We will have a member of the Judicial Council and we will have three elected delegates. It is with regret that I discontinue my services as a Delegate from this body to the national conventions."

President Murphey: "Thank you, Dr. Pearson."

The Chair recognized Dr. James L. Borland.

Dr. Borland: "Mr. President, in view of Dr. Pearson's statement I offer in nomination the name of Dr. Reuben B. Chrisman, Jr., of Miami."

Dr. Meredith Mallory, Sr.: "Orange County would like to second the nomination."

It was moved that the nominations be closed and the secretary cast the ballot for the election of Dr. Chrisman.

Motion seconded and carried.

Dr. Chrisman was elected for a two year term beginning Jan. 1, 1953.

President Murphey: "The Chair will entertain nominations for Alternate Delegate for a two year term beginning Jan. 1, 1953."

Dr. Homer L. Pearson, Jr.: "I nominate Dr. Frank D. Gray of Orlando."

Dr. Eugene G. Peek, Jr.: "I second the nomination and move the nominations be closed and the secretary cast the ballot for the election of Dr. Gray."

Motion seconded and carried.

Dr. Gray was elected.

The Chair announced the personnel of the three reference committees as follows:

1. HEALTH AND EDUCATION

N. E. DINING ROOM

Edward Jelks, *Chairman*
Frazier J. Payton
William M. Davis
Jere W. Annis
William H. Walters, Jr.

2. PUBLIC POLICY

S. W. PORCH

Walter C. Jones, *Chairman*
Eugene G. Peek, Jr.
Donald W. Smith
J. Maxey Dell, Jr.
Chas. W. Bartlett

President Murphey: "Dr. Hugh G. Reaves has been unavoidably detained. The Chair will appoint Dr. Chas. W. Bartlett in Dr. Reaves' stead."

3. FINANCE AND ADMINISTRATION

MEN'S CARD ROOM

William M. Rowlett, *Chairman*
Shaler Richardson
Franz H. Stewart
William C. Roberts
Duncan T. McEwan

President Murphey: "The Chair will entertain the introduction of resolutions not printed in the Handbook."

Dr. Meredith Mallory, Sr., presented a resolution regarding changing the schedule for the annual meetings of specialty groups. This was referred by the Chair to Reference Committee No. 3, Finance and Administration.

Dr. Ralph S. Sappenfield presented a resolution regarding two laws passed by the 1951 State Legislature relating to practical nurses and physical therapists. This was referred by the Chair to Reference Committee No. 2, Public Policy.

Dr. Ralph S. Sappenfield presented a resolution relative to abolishing the present coroner system. This was referred by the Chair to Reference Committee No. 2, Public Policy.

Dr. Ralph S. Sappenfield presented a resolution assigning specific duties and responsibilities to the first vice president of the Association. This was referred by the Chair to Reference Committee No. 3, Finance and Administration.

Dr. Ralph S. Sappenfield presented a resolution urging the Florida State Legislature to memorialize the Congress to limit its powers to levy and collect Federal income taxes. This was referred to Reference Committee No. 2, Public Policy.

President Murphey: "Are there any other resolutions to be presented from the floor?"

The following committee reports were referred as published in the Handbook:

(To Reference Committee No. 1)

Scientific Work, James N. Patterson
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Frazier J. Payton
Venereal Disease Control, Frank J. Pyle
Tuberculosis and Public Health, Alvin L. Stebbins
Maternal Welfare, E. Frank McCall
Child Health, Egbert V. Anderson

(To Reference Committee No. 2)

Conservation of Vision, R. Renfro Duke
Legislation and Public Policy, Eugene G. Peek, Sr.
Medical Education and Hospitals, Julius C. Davis
Public Relations, Eugene B. Maxwell
Medical Economics, Merritt R. Clements
State Controlled Medical Institutions, William D. Rogers
Representatives to Industrial Council, Charles R. Burbacher
Grievance, Walter C. Payne
Appointment of Medical Examiners, Raymond R. Killinger

Resolution: Recommendations to Governor on Appointments to Florida State Board of Medical Examiners.

(To Reference Committee No. 3)

Board of Governors, David R. Murphey, Jr.
Interrelationship, Henry J. Peavy, Sr.
Necrology, Joseph Halton
Advisory to Woman's Auxiliary, C. Robert DeArmas
Councilor Districts and Council, William C. Roberts
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, James L. Borland

Dr. David R. Murphey, Jr., chairman of the Board of Governors, presented a supplemental report. This was referred by the Chair to Reference Committee No. 3, Finance and Administration.

President Murphey: "Necrology. Dr. Halton is unable to attend. I will read his supplemental report." This was referred by the Chair to Reference Committee No. 3, Finance and Administration.

The Chair recognized Dr. Louis M. Orr, II, chairman of the Credentials Committee.

Dr. Orr: "If any of the following delegates are here and have not registered, please do so: Drs. Laurie J. Arnold, Jr.; Candler K. Hayes; James B. Parramore; William H. Walters, Jr.; N. Worth Gable; Hugh G. Reaves; C. LeRoy Adams, Jr.; Arthur G. Williams, Sr.; and Chas. J. Collins."

There being no further business, the House of Delegates recessed at 11:05 a.m. to reconvene at 10:30 a.m., Wednesday, April 30, 1952.

Second House of Delegates

The House of Delegates reconvened at 10:30 a.m., Wednesday, April 30 in the Sun Room of the Hollywood Beach Hotel, Hollywood; President Murphey in the Chair.

Dr. Louis M. Orr, II, Chairman of the Credentials Committee, was recognized and reported that there were 99 delegates present.

The Chair stated that a quorum was present.

Dr. Walter C. Jones moved that the delegates be seated.

Motion seconded and carried.

Later 7 delegates arrived making a total of 106.

Delegates

ALACHUA—J. Maxey Dell, Jr., James M. McClamroch
BAY—William C. Roberts
BREVARD—Thomas C. Kenaston
BROWARD—Russell B. Carson, Richard A. Mills, Leigh F. Robinson, *(Absent—M. Austin Lovejoy)*
COLUMBIA—Laurie J. Arnold, Jr.
DADE—Turner E. Cato, Reuben B. Chrisman, Jr., Jack Q. Cleveland, Edward W. Cullipher, DeWitt C. Daughtry, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Raymond L. Evans, Edward F. Fox, W. Tracy Haverfield, Ralph W. Jack, Walter C. Jones, Donald F. Marion, John D. Milton, Benjamin G. Oren, Frazier J. Payton, Homer L. Pearson, Jr., Kenneth Phillips, Warren W. Quillian, Walter W. Sackett, Jr., Ralph S. Sappenfield, George F. Schmitt, Jr., Donald W. Smith, Franz H. Stewart, Joseph S. Stewart, Arthur H. Weiland *(Absent—Nelson Zivitz)*
DeSOTO-HARDEE-HIGHLANDS-GLADES—Hubert W. Coleman
DUVAL—James L. Borland, Frederick H. Bowen, Turner Z. Cason, Frank L. Fort, A. Judson Graves, Karl B. Hanson, Edward Jelks, Raymond R. Killinger, Ferdinand Richards, C. Burling Roesch, W. W. Rogers, Walker Stamps.
ESCAMBIA—Egbert V. Anderson, Herbert L. Bryans, George W. Morse, Walter C. Payne
FRANKLIN-GULF—*(Absent—Albert L. Ward)*
HILLSBOROUGH—Chas. W. Bartlett, Herschel G. Cole, Samuel G. Hibbs, Eugene B. Maxwell, James N. Patterson, William M. Rowlett *(Absent—Joshua C. Dickinson, Leffie M. Carlton, Jr.)*
INDIAN RIVER—Erasmus B. Hardee
JACKSON-CALHOUN—Daniel A. McKinnon
LAKE—*(Absent—C. McK. Tyre)*
LEE-CHARLOTTE-COLLIER-HENDRY — William H. Grace
LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON —Taylor W. Griffin, Francis T. Holland, William D. Rogers
MADISON—*(Absent—Candler K. Hayes)*
MANATEE—Millard P. Quillian
MARION—Eugene G. Peek, Jr.
MONROE—Ralph Herz
NASSAU—Benjamin F. Dickens
ORANGE—Duncan T. McEwan, John D. McKey, Meredith Mallory, Sr., Louis M. Orr, II, Frank J. Pyle, Robert L. Tolle *(Absent—Carl D. Hoffmann)*
PALM BEACH—V. Marklin Johnson, Graham W. King, Jr., David A. Newman, Cecil M. Peek, Vale D. Stone
PASCO-HERNANDO-CITRUS — *(Absent — William H. Walters, Jr.)*
PINELLAS—M. Eldridge Black, William M. Davis, Albert R. Frederick, Everett M. Harrison, Francis H. Langley, Alvin L. Mills, Franklin W. Roush, Jr., John P. Rowell
POLK—Jere W. Annis, James R. Boulware, Jr., Ivan W. Gessler, Marion W. Hester
PUTNAM—*(Absent—Lawrence G. Hebel)*
ST. JOHNS—Herbert E. White
ST. LUCIE - OKEECHOBEE - MARTIN — Richard F. Sinnott
SARASOTA—John M. Butcher *(Absent—Hugh G. Reaves)*
SEMINOLE—Frank L. Quillman
SUWANNEE—John N. Sims, Sr.
TAYLOR—*(Absent—Walter J. Baker)*
VOLUSIA—C. Robert DeArmas, Achille A. Monaco, Joseph H. Rutter, Morris B. Seltzer
WALTON-OKALOOSA—*(Absent—Arthur G. Williams, Sr.)*
WASHINGTON - HOLMES — *(Absent — Bayllye W. Dalton)*
ASSOCIATION OFFICERS—David R. Murphey, Jr., Robert B. McIver, Frederick K. Herpel, Edward R. Annis, Samuel M. Day, Shaler Richardson—*(Absent Chas. J. Collins)*

President Murphey: "Are representatives of the Medical Association of Georgia present?"

Dr. John B. Avera of Brunswick, Ga., was recognized.

Dr. Avera: "I would just like to say that I enjoy very much being with the Florida Medical Association. I have learned a great deal. Your enthusiasm is very inspiring. At the present moment we in Georgia hope soon to be right behind you in the strides you have made. You are to be congratulated on your good attendance. I want to commend you on your fine Association."

President Murphey: "Thank you, Dr. Avera."

President Murphey: "Next, we will have the recommendations of Reference Committee No. 1, Health and Education, Dr. Edward Jelks, Chairman."

Report of Reference Committee No. 1

Dr. Jelks: "Mr. President, members of the House of Delegates, your Reference Committee on Health and Education, consisting of Drs. Jere W. Annis, Frazier J. Payton, William M. Davis, and your Chairman were greatly impressed in studying the reports which were handed to us, and impressed with the amount of work that these people have done over the year. We feel that if the Florida Medical Association had done nothing more than this it still would have justified its existence. We are not going to comment on most of these reports because we are recommending all for adoption with a slight amendment in some cases."

Dr. Jelks: "We first considered the report of the Committee on Scientific Work under the Chairmanship of Dr. James N. Patterson. We would like to compliment that committee on the high standard of the papers they selected — also on the symposium and motion pictures. I move the adoption of this report."

Motion seconded and carried.

Report of Committee on Scientific Work

James N. Patterson, *Chairman*

Your Scientific Work Committee met at the George Washington Hotel, Jacksonville, Sunday, Dec. 16, 1951 to choose the papers to be presented at the scientific assemblies of the Association at Hollywood, April 28, 29 and 30, 1952. This was not an easy task because many excellent papers had been submitted. Eight requests for places on the scientific program were made on behalf of out-of-state speakers addressing the various specialty groups. However, preference was given to local physicians who submitted papers of high quality and on a subject, thought by the committee, to be of general interest to most of the members. Only one of the eight out-of-state papers was chosen and the scientific committee regrets not being able to place so many excellent speakers both from the specialty groups and from our own membership.

This year your Scientific Work Committee is trying something different — a symposium. Hypersplenism, the title of this symposium, is very short, but its various manifestations are so common that every physician, no matter whether in general practice or in a specialty, has probably had one or more patients presenting signs of this syndrome such as hemolytic anemia, thrombocytopenic purpura, neutropenia, etc. The moderator, Dr. Steven O. Schwartz of Chicago, is an internationally known hematologist. Six Florida physicians will discuss the different aspects of hypersplenism.

Another innovation this year is the addition of scientific motion pictures. Scheduled for Tuesday morning, April 29, this phase of the program will be presented in the hotel theatre with Dr. Jere W. Annis as moderator.

Your chairman believes the 1952 scientific program to be outstanding in value and interest. The results of our efforts more than justify the astounding amount of correspondence and other time consuming activities involved. Sincere appreciation is extended to all who have helped to make this year's scientific program a success.

Respectfully submitted,
James N. Patterson, *Chairman*

Dr. Jelks: "The report of the Committee on Medical Postgraduate Course under the chairmanship of Dr. Turner Z. Cason is approved and I move that the report be adopted."

Motion seconded and carried.

Report of Committee on Medical Postgraduate Course

Turner Z. Cason, *Chairman*

The Nineteenth Annual Graduate Short Course for doctors of medicine was held in Jacksonville, June 25-30, 1951, with a total attendance of 172 physicians.

The annual Diabetes Seminar was held in Lakeland, February 1-2, with 61 in attendance.

The Special Short Course primarily designed for residents and interns was presented on November 27-30, in Jacksonville with 18 attending.

An Obstetrical Seminar with limited registration of 20 was held in Jacksonville on October 23-25, with a registration of 19.

The Special Course just prior to the Short Course was devoted to Hematology and was held in Jacksonville, June 21-23, with 82 in attendance.

These courses were outlined and approved by the Medical Postgraduate Course Committee and preparation was made by the Department of Medicine of the Graduate School of the University of Florida.

The annual Ophthalmology and Otolaryngology Course was held in Miami on January 15-20, with 144 physicians attending.

The Medical Postgraduate Course Committee met at the George Washington Hotel, Jacksonville, on September 30, 1951. Dr. Turner Z. Cason, Chairman, Dr. Robert J. Patterson and Dr. Knox E. Miller attended as well as Dr. Chas. J. Collins and Dr. Frederick K. Herpel who were invited to be present during the proceedings.

The Chairman reviewed the part the Department of Medicine should play in the future medical school's graduate department as well as the integral and important part the Postgraduate Committee has in this respect.

The Committee approved the dates of June 23-28, 1952 for the Twentieth Annual Graduate Short Course. Suggestions were made and recorded for new teachers in the fields of obstetrics, medicine and surgery for this Short Course. For the Special Course prior to the Short Course suggestions were offered by the Committee members as to subjects and lecturers. The question of presenting the Diabetes Seminar in West Palm Beach was discussed and it was the decision of the group that the Chairman should write key men in that city for their opinion.

The Committee was presented with the names of Dr. Joseph A. J. Farrington, Dr. Floyd K. Hurt and Dr. J. Maxey Dell, Jr., for their approval as Faculty members of the Department of Medicine as they had been recommended to the Director by the Chairman of their Divisions in the Department of Medicine. These men were approved by the Committee and this recommendation will be submitted to the President of the University and the Board of Control.

A discussion of the Faculty meeting of the Department of Medicine of the Graduate School of the University of Florida that morning and attended by the Committee members was held, and the decision of the Faculty Chairmen to present such courses in graduate medicine as desired by the different county medical societies was approved by the Committee.

The Statement of Receipts and Disbursements, from July 1, 1950 to July 1, 1951, was presented. It showed that receipts from registration fees amounted to $3,080.00, to which was added the Florida Tuberculosis and Health Association's assistance check of $300.00, making a total of $3,468.60 ($88.60 accounts receivable from 18th Short Course). Disbursements for that same period, which do not include the expenses incurred by the State Board of Health to cover printing of programs, honorariums and expenses for the pediatrician, gynecologists and obstetrician participating in the 1951 Short Course, were in the amount of $2,341.73. Balance on hand July 1, 1951, was $3,724.63.

Respectfully submitted,
Turner Z. Cason, *Chairman*

Dr. Jelks: "The Report of the Committee on Cancer Control, presented by Dr. Frazier J. Payton, Chairman, is approved. I move its adoption."

Motion seconded and carried.

Report of Committee on Cancer Control

Frazier J. Payton, *Chairman*

The activities of your Committee this past year have been largely the activities of its representatives on the Florida Cancer Council. The other members of the Committee have aided materially in disseminating information about the Council activities where possible: the Crossroads Seminar, and the Orlando session of the Cancer Seminar sponsored by the American Cancer Society and the Florida State Board of Health. They have also aided in gathering information for contemplated recommendations of the Council. Your Chairman is grateful to them.

The Florida Cancer Council has held four meetings with almost 100 per cent attendance: May 11, 1951 at Palm Beach; Aug. 24, 1951 at Tampa; Nov. 30, 1951 at Orlando; Jan. 18, 1952 at Tampa. Active discussions have involved especially the following major items:

1. Problems pertaining to Tumor Clinics in the State, especially Jacksonville and Tampa.
2. The Desirability of Tumor Clinic Directors passing on the indigency of cancer patients, although they have already been screened by private physicians or the Health Officer, or both.

3. Lack of availability of funds for Cancer Control from the Florida State Board of Health, due to reduction of specified appropriation by our last Legislature.
   (a) The particular problem presented to Pathologists and Radiologists because of the above.
4. Recommendations to the State Board of Health regarding fee payments to physicians of all categories for State Aid patients. This controversial subject has been a source of major discussion and is not yet completely settled, largely due to the peculiar problems of specialized groups and geographical differences over the State.
5. Discussions at its last meeting on standards for the establishment of new Tumor Clinics with special reference to State adaptability of standards set up by the American College of Surgeons.

Further work on this and many related subjects are under special subcommittee investigation at this time. It is hoped that the members of the Florida Medical Association, and especially the members of the House of Delegates will be indulgent with its Committee on Cancer Control in the furtherance of the work of the Florida Cancer Council. It is anticipated that the Cancer Committee members will be called upon for much more active participation in these problems in the ensuing year.

Respectfully submitted,
Frazier J. Payton, *Chairman*

Dr. Jelks: "Next we would like to recommend approval of the report of the Committee on Venereal Disease Control, presented by Dr. Frank J. Pyle, Chairman, with the following amendments:

"(1) Substitute for paragraph 3 the following: 'No attempt has been made for any mass serology tests for syphilis, although at a meeting of representatives of the Committee on Venereal Disease Control, Defense Program, Blood Bank and the Florida State Board of Health held in Orlando in July 1951 a plan for blood testing was discussed.'

"(2) In paragraph 2 page 19 of the Handbook after the words 'We recommend' there be inserted 'the Committee on Venereal Disease be authorized to conduct.'

"I move the report be adopted as amended."

Motion seconded.

President Murphey: "Is there any discussion?"

The Chair recognized Dr. James N. Patterson.

Dr. Patterson: "I would like to say a word against it. We have blood banks throughout our state. We have a system of blood banks that has been doing blood grouping and typing for a long time. The State Board of Health has not been doing this work. I think it should be kept on the local level."

The Chair recognized Dr. Frank J. Pyle, Chairman of the Committee on Venereal Disease Control.

Dr. Pyle: "It was not the intention of the Committee to take blood grouping and blood typing out of the blood bank and the blood banks would continue to do the typing entirely. The State Board of Health would continue to perform serology tests as they have been doing in the past. The success of such ventures depends on the cooperation of the Committee, the blood banks and the State Board of Health, but the work of the Committee would still remain under the control of the Florida Medical Association through the Venereal Disease Control Committee."

The Chair recognized Dr. Chas. W. Bartlett.

Dr. Bartlett took the floor to emphasize and affirm the objections brought out by Dr. Patterson.

President Murphey: "Any further discussion?"

The Chair recognized Dr. Herbert L. Bryans, President of the Florida State Board of Health.

Dr. Bryans: "It is the wish and desire of the State Board of Health to cooperate fully with the Committee on Venereal Disease Control and to carry out only such tests and operations as requested by the Committee."

President Murphey: "Is there any further discussion?"

Dr. Jelks: "We are glad of this discussion. I wish we had had it before the reference committee."

President Murphey: "Gentlemen, are you ready for the question?"

The Chair called for a standing vote.

Motion carried.

Report of Committee on Venereal Disease Control

Frank J. Pyle, *Chairman*

Although no meeting of this committee was held in the past year your chairman has contacted all members obtaining their recommendations for improving the control of venereal disease in Florida. My report will incorporate their suggestions and activities either now in motion or advised for further action.

Statistically we show a satisfactory reduction in the incidence of venereal disease in the state but united action should result in a more impressive record. Even with the increase in mobilization there was a decrease of 12 per cent in the incidence of syphilis in 1951 over 1950. The records show the cases treated are almost equally divided between clinics and private physicians. There is a corresponding decrease in the incidence of all other venereal diseases.

No attempt has been made for any mass serology tests for syphilis, although at a meeting of representatives of the Committee on Venereal Disease Control, Defense Program, Blood Bank and the Florida State Board of Health held in Orlando in July 1951 a plan for blood testing was discussed.

Treatment of the venereal diseases has improved, paralleling the progress achieved by the new miracle drugs. The treatment of syphilis has been improved and simplified and is rapidly approaching the stage where the family physician can treat this disease with results approaching that of the clinics or by syphilologists. Standardization of the method of treatment will make this problem a simpler one.

For the benefit of physicians treating syphilis, we have arranged programs in the form of round table discussions

covering the interpretation of serology tests and the current recommended treatment. These programs have been offered to all county medical societies and are being carried out throughout the state at the present time.

We realize there is a lack of efficient reporting and follow-up on contact cases of syphilis. Often the physician is too busy or is not sufficiently cognizant of the importance of this phase of control to obtain and report contact cases. If the family physician expects to assume the responsibility of treating these cases he must also assume his share of the responsibility of its prevention and control. The Florida State Board of Health offers capable and trustworthy interrogators who will investigate private cases for contacts. This can be carried out in the physician's office without the patient losing confidence in his physician.

Some action is necessary in regard to the problem of "prostitutes." The American Medical Association House of Delegates passed in 1942 and reaffirmed in 1945 the following resolution: "First, that the control of venereal disease requires the elimination of commercialized prostitution; second, that medical inspection of prostitutes is untrustworthy, inefficient, gives a false sense of security and fails to prevent the spread of infection; third, that commercialized prostitution is unlawful and physicians who knowingly examine prostitutes for the purpose of providing them with medical certificates to be used in soliciting are participating in an illegal activity and are violating the principles of accepted professional ethics." This problem is becoming even more important with the increase of the armed forces in our state.

In consideration of the importance of the control of venereal disease in Florida and to encourage a closer cooperation between the physicians and the State Board of Health we recommend that the committee on Venereal Disease Control be authorized to conduct:

1. (a) A state wide mass blood testing for syphilis alone, or
   (b) A state wide mass blood testing, including RH type, blood type and serology, in cooperation with the Defense Program, the State Blood Bank Association and the State Board of Health.
2. A standard method of treatment be submitted to all physicians in the state.
3. Venereal disease contacts be obtained and reported by the family physician or by interrogators from the State Board of Health working in conjunction with the family physician.
4. Reaffirmation of the action taken by the American Medical Association House of Delegates in 1942 and 1945 on the Examination and Certification of Prostitutes.

Respectfully submitted,
Frank J. Pyle, *Chairman*

Dr. Jelks: "The report of the Committee on Tuberculosis and Public Health presented by Dr. Alvin L. Stebbins, Chairman, is approved with the following amendment: Substitution for paragraph 2 with the following: 'Your committee was asked to act on a request by the State Board of Health to do hemoglobin estimations in connection with a hookworm survey. This request was approved. In the future such tests are to be made with the expressed approval of the involved county medical society.' I move the report be adopted as amended."

Motion seconded by Dr. Arthur H. Weiland.

Motion carried.

Report of Committee on Tuberculosis and Public Health

Alvin L. Stebbins, *Chairman*

It has not been necessary for this committee to hold a formal meeting this year. Activities needing attention were handled through correspondence.

Your committee was asked to act on a request by the State Board of Health to do hemoglobin estimations in connection with a hookworm survey. This request was approved. In the future such tests are to be made with the expressed approval of the involved county medical society.

The committee has not been called on this year in regard to the Diabetes Control project.

We believe that excellent progress is being made to combat tuberculosis in Florida but we realize that it is a continuing fight and there can be no curtailing of activities.

Respectfully submitted,
Alvin L. Stebbins, *Chairman*

Dr. Jelks: "The report of the Committee on Maternal Welfare, presented by Dr. E. Frank McCall, Chairman, is approved, and I move the report be adopted."

Seconded by Dr. Walter C. Jones.

Motion carried.

Report of Committee on Maternal Welfare

E. Frank McCall, *Chairman*

We now have Maternal Welfare Committees in the following counties:

Alachua, Dade, Duval, Escambia, Hillsborough, Leon, Orange, Palm Beach, Pinellas, Sarasota, Suwannee, Volusia and Walton.

The following have been formed in the period 1951-1952:

Escambia, Pinellas, Sarasota, Suwannee, Volusia and Walton.

These Maternal Welfare Committees are doing a good job in reviewing the maternal deaths within their counties and their criticisms and comments are helping a great deal in the prevention of further deaths. The Maternal Welfare Committee, sponsored morally and financially by the Florida State Board of Health, held an Obstetrical Seminar at Daytona Beach September 8, 9 and 10 of last year. The faculty for this meeting was:

Dr. F. Bayard Carter, Duke University; Dr. R. Gordon Douglas, Cornell Medical School, New York; Dr. Carl P. Huber, Indiana University; Dr. Edith L. Potter, University of Chicago; Dr. Perry P. Volpitto, University of Georgia; Dr. Richard Torpin, University of Georgia; Dr. Charles C. Chapple, University of Pennsylvania.

This meeting was attended by 208 physicians which included specialists in the field of Obstetrics and Pediatrics as well as general practitioners. The meeting was well received and plans are in progress to repeat at the same locality in September of 1952.

Funds have already been appropriated for this meeting by the Florida State Board of Health. A canvass of Florida physicians indicates that 193 physicians so far have signified their willingness to attend. Georgia has agreed to subsidize 50 physicians for this meeting and South Carolina 25. We feel that through the continued cooperation of the various local Maternal Welfare Committees and through meetings such as the aforementioned one, that we will see some reduction in the maternal mortality rate in the State of Florida within the next year or so and hope that we will be among the top within a period of five years.

In this report, I would like to thank Dr. Frances E. M. Read of the Florida State Board of Health for her untiring efforts in behalf of the State Maternal Welfare Committee

and to thank the State Board of Health for the financial assistance which enables us to work for the continued reduction of maternal mortality.

Respectfully submitted,
E. Frank McCall, *Chairman*

Dr. Jelks: "The report of the Committee on Child Health, presented by Dr. Egbert V. Anderson, Chairman, is approved, and I move the report be adopted."

Seconded by Dr. Walter C. Jones.

Motion carried.

Report of Committee on Child Health

Egbert V. Anderson, *Chairman*

Your committee on child health during the year 1951 and 1952 has continued with the idea of cooperation with and coordination of all agencies and programs dealing with child health and welfare in the state of Florida. The committee met as a group Nov. 11, 1951 during the meeting of the Florida Pediatric Society and all members were present except Dr. Daniel F. H. Murphey. Meeting with the committee at that time were Dr. Frances E. M. Read of the Florida State Board of Health, Dr. James R. Boulware, Jr., state chairman for the Florida Academy of Pediatrics, Dr. Warren W. Quillian, President of the American Academy of Pediatrics. There was no action taken at this meeting but discussion of ways better to carry out and coordinate the programs now underway were discussed.

The committee is cognizant among others of the following programs that are taking shape in the state for the improvement of child health and welfare. The premature care station in Jackson Memorial Hospital in Miami is continuing to improve facilities and activities and there is hope that other premature stations may be set up over the state. The mental health program of the State Board of Health and local communities continues and has added a clinic in Duval County during this year. The cerebral palsy program sponsored by the Crippled Children's Commission has made progress with the addition of evaluation and treatment clinics in additional sections of the state. Also there has been some effort at coordinating the activities of the Crippled Children's Commission and the Florida Society for Crippled Children. A seminar for Pediatricians and Obstetricians, held in Daytona Beach during the year on maternal and child care was attended by a large number. The committee is cognizant of need of much improvement in the question of infant mortality and has been in cooperation with the State Board of Health in trying to improve it. Support and advice has been given concerning a potential program for reducing accidental mortality among children. This has been sponsored this year in compliance with the program of the American Academy of Pediatrics. It is the recommendation of this committee that continued work be carried on to coordinate and improve all efforts toward child health and welfare in the state of Florida.

Respectfully submitted,
Egbert V. Anderson, *Chairman*

Report of Reference Committee No. 2

The Chair called upon Dr. Walter C. Jones, Chairman of Reference Committee No. 2, Public Policy, to present the recommendations of that committee.

Dr. Jones: "Mr. President, members of the House of Delegates, and guests, your Reference Committee No. 2 is composed of Dr. Eugene G. Peek, Jr., Dr. Donald W. Smith, Dr. J. Maxey Dell, Jr., Dr. Chas. W. Bartlett and myself, as Chairman."

Dr. Jones: "The report of the Committee on Conservation of Vision, presented by Dr. R. Renfro Duke, Chairman, is approved, and I move the report be adopted."

Dr. Leigh F. Robinson: "I second the motion."

Motion carried.

Report of Committee on Conservation of Vision

R. Renfro Duke, *Chairman*

The Committee on Conservation of Vision has conferred informally during the year by correspondence and personal interview. It is pleased to commend the excellent cooperation of the members of the Florida Medical Association with state and other agencies in their efforts to conserve vision.

It is noteworthy that the client registration of the Florida Council for the Blind has mounted yearly, rising from 695 in 1942 to 1,884 in 1951, and totaling 10,220 cases for the decade. The latest figures available showed an active registration of 5,816, and 4,339 clients with services completed; active registration of children numbered 1,213. The Council works closely with its Medical Advisory Committee, composed of ophthalmologists who are members of the Association. Last year it reported complete cooperation of 67 ophthalmologists strategically located throughout the state, who furthered the work of the Council by performing 302 operations on its clients, making 2,346 ocular examinations and giving 368 medical treatments.

Cooperation in the dissemination of literature for the laity, designed to publicize sight conservation and prevention of blindness, is likewise to be commended and also to be encouraged. In the health education of the public, there continues to be great need to stimulate awareness of the early signs and symptoms of glaucoma and to stress the importance of early detection and sustained therapy in order to combat this widely prevalent cause of blindness. Recently it was estimated that at least 800,000 Americans are unaware that they have this insidious disease, which is the cause of blindness in approximately 12 per cent of some 260,000 blind persons in this country. Not alone the ophthalmologists, but all members of the Association, particularly the general practitioners, are urged to promote the sight conservation program with emphasis on early diagnosis of conditions involving sight, such as glaucoma and strabismus, and also on accident prevention.

The Committee desires to direct attention to the excellent service rendered the indigent by free eye clinics in several of the larger cities of the state. This specialized care is made possible through the initiative, generosity and untiring efforts of members of the Association.

Respectfully submitted,
R. Renfro Duke, *Chairman*

Dr. Jones: "Next is the report of the Committee on Medical Education and Hospitals presented by Dr. Julius C. Davis, Chairman. We approve this report with the following amendment: 'It is urged that the inspection of hospitals be carried further. In view of the great amount of money that is being expended by the public in Florida on hospitals, it is suggested that the requirements of staff membership in these hospitals be carefully studied. Staff By-Laws should set up requirements for membership without mention of county

medical society membership. The courts of Florida have ruled that a hospital staff is responsible to the public for the staff membership and grade of service dispensed to the public.'

"We feel that this is a very important committee and urge that county societies cooperate to the fullest extent. I move the report as amended be adopted."

Dr. Richard A. Mills: "Seconded."

Motion carried.

Report of Committee on Medical Education and Hospitals

Julius C. Davis, *Chairman*

This Committee has not assembled for any meetings. However, the Chairman corresponded with the members and asked for suggestions.

Hospital inspection was very limited, but the Chairman personally visited the new hospitals in Chipley, Marianna, Panama City, Pensacola, Tallahassee, and the one soon to be completed in Quincy. Many small hospitals are springing up, almost like mushrooms, over the state in rural districts. These will no doubt prove beneficial from many standpoints and will encourage young men to enter the rural areas where there are ample facilities with which to work. It is to be hoped that these young men will also realize their limitations.

Our Committee was assigned the additional work of urging gifts to the American Medical Education Foundation. Various committees were appointed from the county medical societies to work with your Chairman. Your Chairman, by special letter, urged each committeeman to put forth every effort to secure as much aid as possible from each unit. To date no reports have been received from these county committees, but it is probable that they have gone forward and received contributions which have been sent on to the central committee in Chicago. At some later date your Chairman may be statistically informed as to what contributions have been made by the medical profession of our state. Some gifts have gone to special colleges, and others have been made directly to the national headquarters.

No doubt any failure of our Association to do its full share may be attributed in part to the lack of aggresiveness in your Chairman. When reluctant to accept the Chairmanship, I was advised that there was little work attached. Later I learned that this was a mistake and that a great deal should be done by this Committee.

It is urged that the inspection of hospitals be carried further. In view of the great amount of money that is being expended by the public in Florida on hospitals, it is suggested that the requirements of staff membership in these hospitals be carefully studied. Staff By-Laws should set up requirements for membership without mention of county medical society membership. The courts of Florida have ruled that a hospital staff is responsible to the public for the staff membership and grade of service dispensed to the public.

Respectfully submitted,
Julius C. Davis, *Chairman*

Dr. Jones: "The report of the Committee on Public Relations, presented by Dr. Eugene B. Maxwell, Chairman, is approved with commendations for the ingenuity and energy used by this committee. I move the report be adopted."

Dr. Herschel G. Cole: "Seconded."

Motion carried.

Report of Committee on Public Relations

Eugene B. Maxwell, *Chairman*

Two new projects were added to the public relations program of the Florida Medical Association — Fair Exhibit and Rural Educational Program.

The Fair Exhibit was planned and constructed with the assistance and talent of persons living in Florida. Its first showing was in February, 1952, at the Florida State Fair in Tampa.

The Exhibit is so constructed that it can be dismantled and set up for showing at any county fair wherever a county medical society would like to sponsor it. It is built in sections for fitting into varying space. A schedule of showings will be worked out with the guidance of county medical society officers, and, as the Exhibit has been constructed for relative permanence, all persons in the state should have the opportunity to view it within the next few fair seasons.

The Rural Educational Program is a cooperative venture with the Florida Agricultural Extension Service planned in an effort to reach a group of people with medicine's story. Working with Agricultural Extension Service personnel (county and home demonstration agents), we have agreed to furnish them literature, films, physician speakers, radio transcriptions and the Fair Exhibit when available. Three doctors have spoken in behalf of the Program and 19,430 pieces of literature have been distributed.

Throughout the year, 17 radio stations scattered throughout the state have been broadcasting transcribed programs approved by the County Medical Societies. Through December 1951, a total of 62 sets of transcriptions had been used. This represents 201 hours of continuous broadcast time. To further create good will between Florida's radio men and the medical profession a speaking engagement was filled by a physician at the annual meeting of the Florida Association of Broadcasters in St. Petersburg. A certificate of appreciation was presented by the local county medical society to a station in Orlando that had been carrying a program for four years, a record for such broadcasts in Florida.

Four county medical societies have had live radio programs with actual physician participation.

The weekly newspaper releases, "Health Topics," prepared for 86 newspapers were edited and approved.

In the National Educational Campaign designed among other things to prevent compulsory health insurance and recommend for our citizens voluntary health insurance, more than 19,430 pieces of literature have been sent out.

The Essay Contest among junior and senior high school students was conducted again this year following approval by the state superintendent of public instruction.

Your committee desires to express appreciation for splendid cooperation and help from the staff of the Bureau of Public Relations located in the Association headquarters at Jacksonville.

Respectfully submitted,
Eugene B. Maxwell, *Chairman*

Dr. Jones: "The report of the Committee on Medical Economics, presented by Dr. Merritt R. Clements, Chairman, is approved with commendations, and I move the report be adopted."

Motion seconded and carried.

Report of Committee on Medical Economics

Merritt R. Clements, *Chairman*

There has been only one request referred to this Committee, which proposed the idea that a fixed minimum schedule of fees be posted in each doctor's reception room. The Committee voted against this suggestion.

All County Medical Societies were contacted by mail in regards to Medical Economics. From these reports, the following facts were brought out:

The economic conditions throughout the State are good.

The suggestions for improvement in general were:

1. Continued encouragement in voluntary prepaid insurance.
2. Better liaison between physicians, hospitals, patients and insurance carriers so that better understanding of the coverage and better coverage can be obtained.
3. An active Medical Economics Committee in each County Medical Society to work closely with the Public Relations and Grievance Committees. The Medical Economics Committee, the Public Relations Committee, and the Grievance Committee must be in close contact due to their mutual problems.
4. Informing the patient as to the fee as soon as practicable, preferably before the work is done.

The Committee feels that the absence of complaints and the good reports from the County Societies lead to the conclusion that continued progress along the lines already laid down will result in sound Medical Economics.

Respectfully submitted,
Merritt R. Clements, *Chairman*

Dr. Jones: "The report of the Committee on State Controlled Medical Institutions, presented by Dr. William D. Rogers, Chairman, is approved with commendations, and I move the report be adopted."

Motion seconded and carried.

Report of Committee on State Controlled Medical Institutions

William D. Rogers, *Chairman*

As Chairman of the Committee on State Controlled Medical Institutions I wish to submit the following report on the Florida Farm Colony, Gainesville, Florida; the Florida State Hospital, Chattahoochee, Florida; and the Florida State Hospital located at Arcadia, Florida, which is a branch of the hospital at Chattahoochee.

On a recent visit to the Florida Farm Colony I found the population of that institution to be 609. This is an institution for mental defectives and epileptics under the age of 21. There are no facilities at present for Negro patients. There are also 234 applications pending for admission and most applicants have to wait an average time of from eighteen to twenty-four months to gain admission.

I find that the program has improved and expanded in the last year or so by the employment of additional professional personnel. They have one full time resident physician, four registered nurses, a part-time dentist, an occupational therapist, and their regular school department, carrying out state prescribed studies through the fourth grade. Efforts are now being made to secure the services of a psychologist.

The last Legislature provided funds for the construction of eight additional ward buildings. These buildings will house approximately 300 additional patients. Half of these will provide the first facilities available at the Colony for Negro patients.

The patients in that institution appeared to be receiving very excellent and sympathetic care.

The Florida State Hospital at Chattahoochee at present has a total population of 6,074 patients, including both sexes and colors.

The last Legislature provided sufficient funds to establish three 8-hour shifts, which were put into effect Aug. 16, 1951. Prior to this employees of the Florida State Hospital had been working two 12-hour shifts.

The Legislature also provided money to construct two ward buildings, one for Negro women and one for Negro men, to somewhat relieve the over-crowded condition of these departments. These buildings are in the planning stage at present and construction should start at an early date.

There is also under construction at present a receiving hospital for white men, which will house 150 patients. This will provide adequate reception service as well as additional treatment facilities.

The Florida State Hospital in addition to the regular psychiatric staff employs specialists in the various fields, such as pathology, radiology, tuberculosis, EENT, general surgery, and internal medicine.

The Clinical Laboratory is approved for technicians' training and the institution operates an approved School of Nursing Education. There is also a very fine occupational therapy program under way and an expanding recreation program.

The present admission rate to the institution averages about 150 patients per month, or 1,800 per year. Due to the many chronic type cases received the institution has to plan for a gain of roughly 250 patients per year in permanent population. Certainly some thought should be given at an early date to the establishment and construction of more mental hospitals over the State.

The Florida State Hospital at Chattahoochee at the present time employs 1,487 persons.

The Florida State Hospital, Arcadia. This branch hospital was established in 1947 by converting the facilities of two air fields into use for patient care. It was established to relieve the over-crowded conditions at the Florida State Hospital, Chattahoochee, and the first patients were placed there in February of 1947. At present there is a population of 888 consisting of white men and white women.

Plans are now under way to add more housing facilities for patients at this institution, which will give additional space for 175 white men and 100 white women.

There are 285 employees at the branch hospital in Arcadia.

The most noticeable and most critical condition observed is the marked over-crowding at all institutions under report.

Respectfully submitted,
William D. Rogers, *Chairman*

Dr. Jones: "The report of the Grievance Committee, presented by Dr. Walter C. Payne, Chairman, is approved. We wish to commend Dr. Payne for an excellent report and recommend its publication in the state and county bulletins. I move the report be adopted."

Motion seconded and carried.

Report of Grievance Committee

Walter C. Payne, *Chairman*

Serving as Chairman of your State Grievance Committee is a revealing experience and certainly a most interesting one. One is surprised at the comparatively small number of general categories into which a large majority of complaints can be placed. We have found that most of the grievances come under one of the following four headings:

1. As one would surmise, the largest number of complaints arises over fees charged by our members. We find that the dissatisfaction about the charges for professional services arises because the physician either did not take the time to discuss the fee prior to rendering the service, or even to discuss the fee with the patient when a protest was made. Some of our members seem to take offense if their patients ask for an explanation of the charges. In most of the cases, the complainant would have been satisfied with the fee charged if he or she had been given an explanation.
2. The fees charged by an assistant is a frequent cause of misunderstanding. When arrangements

are made for an operation and a price quoted, often there is no mention made of an assistant's fee. The patient is surprised then to receive a statement for services rendered from a physician whom he does not know and had not been informed had been an assistant at the operation. It is obvious that, if there is to be an assistant fee, this should be explained to the patient.

3. Refusal to itemize a statement for services rendered is another frequent source of dissatisfaction. We have had complaints that the request for an itemized statement was either refused or ignored. Your Committee feels, and the American Medical Association feels, that a patient has a right to an itemized statement if he desires one.

4. Under a fourth heading we find the group of frivolous or unreasonable complaints. As can be imagined, when dealing with our entire population there are some unreasonable complaints. What we would like to emphasize is that many of these complaints can be satisfied by a little tact and patience. Every complainant deserves a serious and dignified consideration. If given such a hearing, many complainants can be shown that the complaint was unreasonable. And the mere fact of having the complaint handled as though the complainant's opinion is important and will go far toward a peaceful understanding. We should keep in mind constantly that one of the reasons for the creation of a Grievance Committe is to improve our public relations. And we need the good will of everyone, the reasonable and unreasonable unlike.

Your Committee would like to urge each County Committee to act promptly when a complaint is referred to it by your State Committee. As you know, it is the policy of the State Committee to refer all complaints to the County Committee in the County from which the complaint originates. The State Committee acts only on those cases where an appeal is made from the County decision, either by the complainant or the one against whom a complaint is made. Delay in handling the complaint is often disastrous. Another thing we wish to call attention to is the necessity of informing a complainant that his grievance is being investigated. After the investigation, the complainant as well as the physician involved should be informed as to the result. This, unfortunately, is not always done. We feel that the necessity for informing both parties of the decision of the Grievance Committee is too obvious to require argument.

Your Committee feels that the number of complaints satisfactorily adjudicated justifies the creation of Grievance Committees. However, as would be expected, in the creation of a new Committee it requires time, patience and hard work to reach maximum efficiency. We feel that when our State Committee has acquired more experience and the County Committees better understand their duties, we will be able to handle complaints more promptly and efficiently.

We wish to express appreciation to the County Committees for the cooperation that they have given.

Respectfully submitted,
Walter C. Payne, *Chairman*

Dr. Jones: "The report of the Committee on Representatives to Industrial Council, presented by Dr. Charles R. Burbacher, Chairman, is approved. I move the report be adopted."

Motion seconded and carried.

Report of Representatives to Industrial Council

Charles R. Burbacher, *Chairman*

Your Chairman wishes to thank the members of this Committee, Drs. Herschel G. Cole, Julius C. Davis, G. Frederick Oetjen, and Chas. L. Farrington for signifying their willingness to serve on this Committee.

No occasion has been presented to necessitate a formal meeting of this Committee. Your Chairman has taken care of several problems that have come up by correspondence, and I am sure that the individual committee members have rendered similar service in this way during the past year. More correspondence has come in recently than during the preceding ten months that this Committee has been in existence.

In the event that any major action or decision is necessary, a supplemental report will be submitted at the annual meeting of the Association in Hollywood.

Respectfully submitted,
Charles R. Burbacher, *Chairman*

Dr. Jones: "We will now consider the resolution in reference to House Bill 302 and House Bill 8 of the 1951 State Legislature, presented by the Dade County Medical Association and, following that, we will immediately consider the report of the Committee on Legislation and Public Policy. The Reference Committee recommends that the Committee on Legislation and Public Policy, at an early date, consider the resolutions on these laws for possible modifications, changes or revisions. After consideration, their recommendations should be referred back to the Board of Governors for approval."

Resolution

BE IT RESOLVED BY THE DADE COUNTY MEDICAL ASSOCIATION MEMBERS CONVENED:

That the Dade County Medical Association proposes that the Committee on Legislation and Public Policy of the Florida Medical Association take under consideration and study carefully two laws passed by the State Legislature at its last meeting; namely, H.B. 302 (Chapter 464, Florida Statute 1951), pertaining to practical nurses, and H.B. 8, (Chapter 486, Florida Statutes 1951), pertaining to technicians practicing physical therapy, with a view to making recommendations to the State Legislature at its next session in 1953 for clearing up ambiguities and confusions in these acts.

Passed by the Dade County Medical Association in Assembly convened on April 1, 1952.

Amendment

The Reference Committee recommends that the Committee on Legislation and Public Policy, at an early date consider the resolutions on these laws for possible modifications, changes or revisions. After consideration these recommendations should be referred back to the Board of Governors for approval.

Dr. Jones: "I move that this resolution with the amendment be approved."

Motion seconded and carried.

Dr. Jones: "The report of the Committee on Legislation and Public Policy, presented by Dr. Eugene G. Peek, Sr., is approved with the following additions: 'It is recommended to the Commit-

tee on Legislation and Public Policy that, since it has been called to our attention that the final drafts of House Bill 302, (Chapter 464, Florida Statutes 1951), House Bill 8, (Chapter 486, Florida Statutes 1951), and amendments to the Medical Practice Act, (Chapter 458, Florida Statutes 1951), were not submitted to the Florida Medical Association for final approval, certain paragraphs in the acts now carried on the statute books be reviewed and studied carefully because they are objectionable to some of our members.'

"It is further recommended that the Committee on Legislation and Public Policy suggest amendments and submit an entire revision to the House of Delegates or Board of Governors for approval before submission to the Legislature."

Dr. Jones: "I move the adoption of this report with the additions."

Seconded and motion carried.

Report of Committee on Legislation and Public Policy

Eugene G. Peek, Sr., *Chairman*

Your Committee has been engaged primarily with activities relative to the 1951 session of the Florida State Legislature. As during previous sessions, an office of information was maintained in Tallahassee for that period. Your Chairman was on duty in Tallahassee for counsel and advice to legislators during the entire session. He was capably assisted by Mr. Tom Stallworth of Florida Blue Shield and Mr. Ben Willis, our legal consultant, of the law firm of Messer and Willis, Tallahassee.

Our chief interest was in following to passage certain amendments to the Medical Practice Act. These amendments were sponsored by the State Board of Medical Examiners and were drafted by a member of the Attorney General's staff. These amendments and two new measures, which were designed to facilitate the activities of the Medical Examining Board, were enacted into laws with almost no opposition.

Considerable time and much tedious labor were devoted to "watch-dog" activities. All bills introduced were carefully checked by title. All those which had any remote possibility of containing sections which would be deleterious to public health were read thoroughly.

A detailed report of these activities was published in the October 1951 issue of The Journal.

This year, as in previous years, a copy of "Today's Health," A. M. A. health magazine for lay readers, is being sent to U. S. Senators and Congressmen, State Senators and Representatives, the Governor and members of his Cabinet by the F.M.A. Bureau of Public Relations.

Your Committee desires to express sincere appreciation for valuable assistance by the Association officers, the managing director and his assistant, the county medical society officers and members of their legislative committees and the Association's Bureau of Public Relations.

Respectfully submitted,
Eugene G. Peek, Sr., *Chairman*

Amendment

It is recommended to the Committee on Legislation and Public Policy that, since it has been called to our attention that the final drafts of House Bill 302, (Chapter 464, Florida Statutes 1951), and House Bill 8, (Chapter 486, Florida Statutes 1951), and amendments to the Medical Practice Act, (Chapter 458, Florida Statutes 1951), were not submitted to the Florida Medical Association for final approval, certain paragraphs in the acts now carried on the statute books be reviewed and studied carefully because they are objectionable to some of our members.

It is further recommended that the committee on Legislation and Public Policy suggest amendments and submit an entire revision to the House of Delegates or Board of Governors for approval before submission to the Legislature.

Dr. Jones: "The Report of the Special Committee on Appointment of Medical Examiners presented by Dr. Raymond R. Killinger, Chairman, is approved. We strongly urge that the President carry out the recommendations of this committee. I move that it be adopted."

Dr. William M. Rowlett: "Seconded."

Motion carried.

Special Committee on Appointment of Medical Examiners

Raymond R. Killinger, *Chairman*

A report on the desirability of establishing a modern scientific medico-legal system for the State of Florida.

Your committee endorses the principles set forth in "A Model State Medico-Legal Investigative System," as drawn up by the National Municipal League, 299 Broadway, New York, N. Y., 1951.

The scientific inadequacy of our present elective coroner's system is apparent to medical men as well as to the law enforcement agencies of the State. This archaic condition can be blamed primarily on general public apathy plus a lack of public knowledge of the situation. A State employs financial experts to handle the relatively cheap commodity, money, and should be even more gravely concerned with the disposition of priceless wealth, the lives of its citizens. Therefore it is the duty of the Florida Medical Association to be deeply concerned by the injustice and tragedy that may and does result from the misinterpretation of medical evidence in the hands of laymen and of physicians lacking experience and technical aids so necessary to establish the true cause and manner of death. To that end the Florida Medical Association, as a public service, unqualifiedly goes on record that a revision of the coroner's system should be made so that:

1. Criminal and civil court procedures shall be provided with documented sound and impartial medical evidence.
2. Deaths due to foul play and misadventures shall be recognized and so stated on the death certificate.
3. Unrecognized hazards to public health shall be revealed.
4. Industrial hazards shall be exposed.

It is our suggestion that the State can best be served by a central medico-legal laboratory, staffed with experts, working with regional investigators (physicians) who have had some basic schooling in the special problems of legal medicine. For the larger centers of our population which already have some form of the medical examiner's system operative, the central special crime laboratory with its skilled assistance would be a welcome supplement to their own activities.

The regional investigators must be men who are not only trained as pathologists, but who have had special interest and training in the field of medico-legal work. This should include knowledge of bullet wounds and their significance, the ability to remove properly and examine the neck organs from a strangulation case, the ability to distinguish between death due to drowning and death pre-

ceding immersion in water, plus a host of many other specialized forms of knowledge essential to the proper performance of their duties. The chief medico-legal expert must have a vast fund of knowledge related to osteology, fingerprinting, handwriting, photography, fabrics, poisons, and ballistics in addition to his basic knowledge of pathology and anatomy, in order to be a guardian of our health and safety.

Therefore, it is the recommendation of your Committee that the President appoint a board from the Florida Medical Association to act in conjunction with the proper State bodies for the early drafting and passage of a modern, scientific, medico-legal system for the State of Florida. It is the further recommendation of your Committee that said act, to be prepared, should conform as largely as possible to the principles laid down in "A Model State Medico-Legal Investigative System," as outlined in part 1, pages 13-18 inclusive.

Respectfully submitted,
Raymond R. Killinger, *Chairman*

Dr. Jones: "In view of your action approving Dr. Killinger's Report on Medical Examiners, we recommend that the resolution to abolish the present coroner system, presented by the Dade County Medical Association be tabled. Dr. Killinger and others appeared before our committee and convinced us that the system that they have recommended amply provides for county examiners. I move approval of this tabling action."

Motion seconded and carried.

Dr. Jones: "Should any of you be interested in this report we have ample supporting material to justify our action."

Dr. Jones: "The resolution on recommendations to the Governor on appointments to the Florida State Board of Medical Examiners presented by the DeSoto-Hardee-Highlands-Glades County Medical Society is approved with the following amendments: (1) That Item 2 read 'The Florida Medical Association shall forward from time to time, through the Committee on Legislation and Public Policy, such lists to the Governor of the State of Florida, as the recommendation of the Association for the consideration of the Governor in his choice of candidates for appointment to such vacancies as may exist.' (2) Also that Item 3 be deleted. I move the resolution be adopted as amended."

Motion seconded and carried.

Recommendations to Governor on Appointments to Florida State Board of Medical Examiners

Resolution

WHEREAS, the selection of doctors of medicine to serve as members of the Florida State Board of Medical Examiners is of vital importance to the entire body of the medical profession in the State of Florida, and

WHEREAS, the duties of the Board of Medical Examiners are highly specialized and professional in character, and

WHEREAS, it is highly desirable to avoid political pressures in the performance of the duties of such examiners, and in so far as possible, to divorce politics from medical practice,

THEREFORE BE IT RESOLVED by the House of Delegates of the Florida Medical Association, duly assembled in regular session this date, that

1. The Florida Medical Association shall through its component and relevant county societies nominate and select from time to time a list of not less than two (or three) candidates for each vacancy that may hereafter exist in the membership of the Florida State Board of Medical Examiners, and

2. The Florida Medical Association shall forward from time to time, through the Committee on Legislation and Public Policy, such lists to the Governor of the State of Florida, as the recommendation of the Association for the consideration of the Governor in his choice of candidates for appointment to such vacancies as may exist.

Respectfully submitted,
Hubert W. Coleman, *Delegate*
DeSoto-Hardee-Highlands-
Glades County Medical Society

Dr. Jones: "We approve the resolution on the power of Congress to levy and collect taxes on incomes beyond the maximum of 25 per cent during peace time presented by the Dade County Medical Association. It is further suggested that each individual contact his state and national legislators urging action along this line. I move the resolution be adopted."

Motion seconded and carried.

Resolution

WHEREAS, the burden of federal income tax has become greater than at any prior period in our history, and

WHEREAS, the taxes imposed by the federal government are destroying incentive and drying up the sources of capital on which our system of private enterprise depends, which will ultimately lead to the destruction of that system, and

WHEREAS, this tax falls heavily on both those with small incomes and those with large incomes,

THEREFORE BE IT RESOLVED: That the Dade County Medical Association in Assembly convened, urge the Florida State Legislature to memorialize Congress to submit for ratification by the legislatures of the states, an amendment to the Constitution of the United States which will limit the power of Congress to levy and collect taxes on incomes beyond the maximum of 25% during peacetime; and

BE IT FURTHER RESOLVED: That a copy of this resolution be presented to the Florida Medical Association House of Delegates at the Convention in April, 1952, and that a copy be sent to each Senator and Member of the House of Representatives of the Florida state legislature. Passed by the Dade County Medical Association in Assembly convened on April 1, 1952.

Report of Reference Committee No. 3

Dr. William M. Rowlett, Chairman of Reference Committee No. 3, Finance and Administration, was recognized and asked to present the recommendations of that committee.

Dr. Rowlett: "Mr. President, members of the House of Delegates, and guests. Reference Committee No. 3, Finance and Administration, has carefully gone over the splendid report of the Board of Governors as presented by Dr. Murphey, Chairman, and approves with the exception of that

portion relating to the fee schedule, which begins with the second paragraph of page 35 of the Handbook, including the resolution on that page, which is deleted at the request of Dr. John D. Milton, Fee Schedule Sub-Committee Chairman.

"In reference to the Committee's recommendation that the Hollywood Beach Hotel in Hollywood be selected as the headquarters for the Association's Seventy-Ninth Annual Convention, the Committee desires to state that they have investigated all of the hotel facilities of the state and find that the Hollywood Beach Hotel is the only one at present that can accommodate our exhibits and the 17 specialty groups under one roof. Mr. Chairman, I move that the report as amended be adopted."

Dr. James N. Patterson: "I second the motion."

Motion carried.

Dr. Rowlett: "Reference Committee No. 3, Finance and Administration, approves the supplementary report of the Board of Governors as read by the Chairman. I move the supplement to the Board of Governors' report be adopted."

Motion seconded and carried.

Report of Board of Governors

David R. Murphey, Jr., *Chairman*

Five meetings of the Board of Governors were held as follows: April 25, 1951, June 3, 1951, October 6, 1951, October 7, 1951 and December 16, 1951. At the last meeting of the Board, every member was present. The faithfulness of the members of your Board to attend meetings at their own expense and time deserves special mention.

The dates for the Seventy-Eighth Annual Meeting of the Association at Hollywood were set for April 28-30, 1952.

An operating budget for the fiscal year beginning April 1951 was presented by Dr. Samuel M. Day, Secretary, and approved.

The schedule to be followed at the Seventy-Eighth Annual Meeting was discussed in detail and approved.

The following members, on recommendation of their local county medical societies were elected to Honorary Memberships: Drs. Lydia A. DeVilbiss, Hewitt Johnston, Charles L. Kennon, Geo. N. MacDonell, Elbert McLaury, Alice R. Miller, Ernest H. Ruediger, Heyward J. Blackmon, N. J. Dawkins, L. H. Paul, W. Duncan Owens, Everett D. Hockenberry, M. C. Wilson, Percy D. Biddle, Alan Brown, Frank J. McKinley, Leo H. Riesenbeck, Meredith Mallory, Jr., Thomas H. Odeneal, Cleveland J. Price, John Shahan, Aris Carpousis and Howard F. Currie.

The President carried on considerable correspondence with Mr. Marion T. Jeffries, State Representative of the National Foundation for Infantile Paralysis, endeavoring to establish a cooperative working relationship between the Florida Medical Association and the National Foundation for Infantile Paralysis. Definite progress was made and reported to your Board from time to time. While a mutual agreement was not completed, there seems to be only one important point of difference and it will undoubtedly be completed in the near future.

At the request of Dr. Leigh F. Robinson, President of Blue Shield of Florida, nominations to fill vacancies on the Blue Shield Board of Directors from the four Medical Districts were made.

A special committee of Board members was appointed to select an Acting Supervisor for the Bureau of Public Relations, as Mr. W. Harold Parham was called back to military service and is in Korea. The committee selected Mr. Norman J. Ulbright for this position and he reported for duty January 2, 1952.

The Field Representative of the Bureau of Public Relations, who was working in the Southeast section of the State, resigned. Considerable time and effort has been put into the engaging of the services of a qualified Public Relations person for field activities and it is anticipated that a satisfactory solution will be reached before the Annual Meeting. There may be one more meeting of the Board of Governors to act on items that will accumulate before the April meeting and, if so, a supplemental report will be taken to the House of Delegates.

Your Board approved the recommendation by Dr. Eugene B. Maxwell, Chairman of the Association's Committee on Public Relations, to have a Florida Medical Association exhibit at the State Fair in Tampa, February 5-16, 1952.

On recommendation by Dr. Eugene G. Peek, Sr., Chairman, Association's Committee on Legislation and Public Policy, your Board approved the employment of Messer and Willis, Tallahassee legal firm, for the period January 1, 1952 to June 30, 1953 for legal counsel.

Your Board approved the appointment of an official representative and alternate to serve on the State Advisory Committee to assist the State Department of Education in making decisions on matters pertaining to the program of Practical Nurse Education, and a representative to serve on the School Health Advisory Council of the Department of Education, as requested by Mr. Thomas D. Bailey, Superintendent, Florida Department of Education.

The 1951 action of the House of Delegates disapproving $500.00 to the University of Florida to support the Bureau of Professional Relations was referred to your Board for further study. Your Board decided to sustain the action of the House of Delegates in disapproving the contribution of $500.00.

Sub-Committee to Board of Governors on Review of Fee Schedules

Your Committee has worked diligently for the past year, having four scheduled meetings with many hours of conferences among its members and with representatives of Blue Shield, Industrial Commission for the State of Florida, Vocational Rehabilitation and Veterans Administration. The committee members are cooperating to the fullest.

The Veterans Administration has not finally approved the fee schedule that the committee recommended last year, but recent correspondence with them advises us that the schedule will be returned within a matter of two or three weeks, then the final negotiations will take place.

Vocational Rehabilitation has been most cooperative and will follow through along the Veterans Administration scale of fees.

A conference with a representative of the Industrial Commission for the State of Florida revealed the fact that he considers the duties of the Commission in administering the Workmen's Compensation Act in reference to fees, etc. as somewhat socialistic in tendency, but the same was demanded at the time of enactment by all interested parties. If the Florida Medical Association desires any change whatsoever in their fee schedule we would have to file a petition with the Commission and have an open hearing so as to make this change. There is no other way in which the fee schedule can be revised. I might say that the representative of the Commission feels that there should be a revision in the schedule.

The Committee further finds that the opinion of the doctors are divided, some are satisfied, but the majority are not. The trained orthopedic surgeon (recognized by the insurance companies) will receive the fees that he charges regardless of the fee schedule, while other individual medical men are held very closely to the 1938 fee schedule. This is a most unhealthy situation. Therefore,

the Committee strongly recommends to the Board of Governors that steps be taken immediately to file a petition with the Florida Industrial Commission for the adoption of a new fee schedule so that an open hearing might be called. It is felt that this is the only democratic way equitably to adjust a fee schedule for the entire membership of the Florida Medical Association.

John D. Milton, *Chairman*

Sub-Committee to Board of Governors on Veterans Care

Your Sub-Committee to the Board of Governors of the Florida Medical Association on Veterans Care during the past year held meetings with the Fee Schedule Committee of which your chairman is a member, and held meetings with representatives of the Veterans Administration in an effort to get certain fees in the Fee Schedule for treating veteran patients elevated. We do not yet know the outcome of these efforts.

During the year 1951 the Veterans Administration in the State of Florida issued 34,353 authorizations to members of the Florida Medical Association for medical service to veterans and paid $358,296 to members of the Florida Medical Association for the treatment of veterans.

Frederick H. Bowen, *Chairman*

Sub-Committee to Board of Governors on Liaison-National Foundation Infantile Paralysis

There is nothing of interest to report from this committee.

Frederick H. Bowen, *Chairman*

Sub-Committee to Board of Governors on Blue Shield

Blue Shield enrollment at the end of 1951 totaled 216,689 members.

During the year $1,583,908.76 was paid for 36,279 cases. Of this number, 31,932 were surgical cases and 4,347 were non-surgical cases for which 29,679 days of service were rendered.

It is interesting to note the procedures which are the most used under the Blue Shield Schedule of Benefits. Following is a run-down of some of these procedures for 1951:

Procedures	Number	Amount Paid
Obstetrical cases	4,415	$342,039.00
Tonsillectomies	3,821	163,715.00
Circumcisions	2,118	23,215.00
Suture of wounds	1,898	25,909.00
Excision of cicatrix and benign neoplasm	1,427	18,316.50
Appendectomies	1,145	136,867.00
Cystoscopies	965	28,599.90

During 1951, 463 participating physicians each received over $1,000 from Blue Shield. Of this number, 106 received over $3,000, 28 received over $5,000 and 2 received over $8,000. Due to increased enrollment and the resultant increase in Blue Shield cases, it is reasonable to assume that the 1952 figures will be even greater.

Non-group enrollment was offered for the first time on a state-wide, year-round basis in the Fall of 1951. This type of enrollment was formerly limited to certain counties during set enrollment periods, usually of two weeks' duration. Enrollment is open to those persons who are under 65 years of age, in good health and permanent residents of Florida and who are unemployed, self-employed, retired, students, or anyone who is not eligible for group enrollment. Non-group subscribers make quarterly payments directly to the Plan office in Jacksonville. No physical examination is required, however, applicants must complete a health questionnaire. Participating physicians may obtain literature on non-group membership in Blue Shield and Blue Cross by writing to the headquarters of the Plans, 532 Riverside Avenue, Jacksonville.

All contributions made by physicians to the working fund of the Blue Shield Plan at the time of its organization have been refunded. This refund was made in June, 1951, and was approved by the Insurance Commissioner of the State of Florida.

Leigh F. Robinson, *Chairman*

* * *

Recommended that the Hollywood Beach Hotel in Hollywood be designated as the meeting place for the 1953 annual meeting. The By-Laws provide that the dates for the meeting shall be set by the Board of Governors.

* * *

Recommendation: Your Board recommends that Chapter XI, Sec. 6, be amended by deleting the words in line 6, "become a member of," and adding in lieu thereof, "apply for membership in."

The 1951 House of Delegates requested the Board to study and consider By-Law Chapter XI, Sec. 6, Par. (104) "Permit Doctors to belong to an adjacent county medical society."

Supplement

After the Handbook for Members of the House of Delegates went to press, a meeting of the Board of Governors was held in Jacksonville, March 23. This supplement, which is in addition to the printed report, is therefore offered to be included as a part of the original report.

It is recommended that Chapter VII, Sec. 9 of the By-Laws be amended by striking out the word "shall" in line 9 and inserting in lieu thereof "may." In line 11, after the words "to be held annually," insert the following: "and other such postgraduate courses as the registration fees will finance. Registration fees collected shall be turned over to the Treasurer of the Florida Medical Association and disbursed as set up in the annual working budget approved by the Board of Governors, the same as all other income."

After line 15, insert a new paragraph as follows: "(B.) This Committee may, as requested, advise and counsel with other organizations offering Medical Postgraduate Courses. The Florida Medical Association shall not act as a depository for fees or donations received by these organizations for such courses."

It is recommended that the following Resolution of the Board of Governors be approved:

Resolution

1. The employee supervising the Bureau of Public Relations should work out of Association headquarters and the salaries of his subordinates should be lower than his.
2. The Supervisor or Acting Supervisor and his subordinates shall assist all county medical societies with their PR programs.
3. Where a county medical society has an active program, a field representative should be detailed from the Bureau to spend sufficient time each week, more or less, to give all possible assistance.
   A. Under this program a representative from the central office will visit any county society when needed to assist with or advise a local program.
   B. This does not imply that the representative will do the actual processing of local activities, except as an initial aid in setting up a program or as authorized by the supervisor in unusual circumstances.

Your Board approved the following Cooperative Working Relationship between the Florida Medical Association and the county chapters of the National Foundation for Infantile Paralysis:

Experience has shown that a closer and more understanding working relationship between the medical profession and the County Chapters of the National Foundation for Infantile Paralysis is needed in the state of Florida. In order to assure such a relationship, the

policies and organization of the National Foundation Chapters and their Medical Advisory Committees have been reviewed on a state level by officials of the Florida Medical Association and the National Foundation for Infantile Paralysis, in consultation with officers of the Hillsborough County Medical Society.

As a consequence, several salient recommendations have been agreed to, which concern the proper organization and functioning of the Medical Advisory Committees of the County Chapters and their working relationship with the County Medical Societies. If these recommendations are allowed, it is believed that organized medicine will feel more direct responsibility toward the medical care program of the County Chapters, and the County Chapters will have the benefit of such support by organized medicine.

The recommendations are:

1. The County Medical Society will nominate the members of the County Chapter's Medical Advisory Committee, after consultation with the Chapter Chairman and the Chapter will then appoint these members as their Medical Advisory Committee.
2. The Chapter will choose, in consultation with the President of the local Medical Society, one member of the Medical Advisory Committee to attend meetings of the Chapter's Executive Committee, as an ex-officio member to act in an advisory capacity to the Executive Committee on their request. This member will not be a voting member, but as stipulated above will serve in an advisory capacity and as liaison between the County Medical Society and the County Chapter.
3. The patient must always have a free choice of physicians.
4. In addition to the County Chapters Medical Advisory Committees, it is planned to form a State Medical Advisory Committee from the Florida Medical Association, to work with the State Representatives of the National Foundation for Infantile Paralysis, to solve problems which may arise in the various counties in connection with the medical care program. This State Medical Advisory Committee would have a representative on the State Polio Planning Committee, to assist the State Board of Health and other interested groups and agencies in making plans to meet the polio problem on a state-wide basis. This representative to be appointed by the President of the State Medical Association.
5. Invitation for the medical profession to participate as an organization in the care of victims of poliomyelitis, to originate with the National Foundation for Infantile Paralysis. Requests for the appointment of the County Chapter Medical Advisory Committee and State Medical Advisory Committee to be issued by the County Chapter and the State office of the National Foundation respectively.
6. The County Chapters of the National Foundation are to carefully consider all requests for financial assistance, and make an earnest effort to educate the family to its responsibility to participate in the expense of medical care and treatment, to the extent of its ability and it is understood that the Chapter policies on financial assistance shall conform with national policies.
7. The National Foundation will give public recognition, in a suitable manner, to the indispensable role played by the medical profession in carrying on the medical care program of the National Foundation.

Proper steps will be taken by the National Foundation for Infantile Paralysis and the Florida Medical Association to inform the County Chapters and the County Medical Societies of these recommendations so that the desired integration of programs can be achieved. Any explanatory information in connection with these recommendations will be furnished as the need is indicated.

President, Florida Medical Association
State Representative, Southern Florida
The National Foundation for Infantile Paralysis, Inc.
(in charge state level contacts)

Your Board notified the Association's Committee on Legislation and Public Policy that the Florida Statute 1951 Chapter 458.13 Par. (3) be amended. It does not reflect our understanding when the bill was brought before the pre-legislative meeting in Ocala.

The following members, on recommendation of their local county medical societies, were elected to Honorary Membership: Drs. Arthur McGugan, Wilson C. Pay, Will L. Wood and Franklin H. Reeder.

Respectfully submitted,
David R. Murphey, Jr., Chairman

Dr. Rowlett: "The Committee approves the report of the Committee on Interrelationship which suggests abolishing said Committee on Interrelationship and recommends that the By-Laws be amended accordingly. Mr. President, I move the adoption of this report."

Motion seconded and carried.

Report of Committee on Interrelationship

Henry J. Peavy, *Chairman*

During the past two years this Committee reported only routine activity and very little of that. We recommend the Committee be abolished and its activities be taken over by the Committee on Public Relations.

Respectfully submitted,
Henry J. Peavy, *Chairman*

Dr. Rowlett: "Reference Committee No. 3, Finance and Administration, has gone over the report of the Committee on Advisory to the Woman's Auxiliary and presented by Dr. C. Robert DeArmas, Chairman, and approves same. I move the report be adopted."

Motion seconded and carried.

Report of Committee on Advisory to Woman's Auxiliary

C. Robert DeArmas, *Chairman*

The Advisory Committee to the Woman's Auxiliary to the Florida Medical Association held no formal meetings during the year. An invitation to attend the meeting of the executive board of the Woman's Auxiliary was extended. Only two members could attend. Certain matters of policy were discussed and after a consultation with the officers of the Florida Medical Association these policies were established and the information sent to the appropriate chairman in each County Medical Society. This information was to be used for the purpose of clarification and uniformity in advising the various County Woman's Auxiliaries. The committee reports a remarkable growth in membership and scope of the Woman's Auxiliary to the Florida Medical Association.

Respectfully submitted,
C. Robert DeArmas, *Chairman*

Dr. Rowlett: "Reference Committee No. 3, Finance and Administration, has gone over the report of the Council, as presented by the Chairman, Dr. William C. Roberts, and approves the same. I move the report be adopted."

Motion seconded and carried.

Report of Council

William C. Roberts, *Chairman*

I wish to thank the eight Councilors, host societies and Woman's Auxiliaries for their cooperation and efforts in making the Medical District Meetings most successful. These meetings were well attended. The scientific programs were excellent, being well prepared and expertly presented. The social atmosphere and fellowship were most enjoyable. The talks by the officers of the Florida Medical Association were specific with emphasis on our endeavors and objectives.

The meetings progressed as scheduled except for the first one at Pensacola, which was saddened by the untimely death of Dr. Joe I. Turberville of Century. The meeting was recessed after the scientific program to permit members to attend his funeral, and was resumed immediately afterwards.

As a suggested recommendation it would be wise to print on the scientific program of the Medical District Meetings the Advisory to Selective Service as this is a most important and timely subject and problem. The chairman of this commmittee presented something that was most interesting to the younger doctors and especially those who are likely to be called into service. This subject would be conducive to them to attend these meetings for this information and to learn their respective statuses with reference to military service.

Respectfully submitted,
William C. Roberts, *Chairman*

Dr. Rowlett: "Reference Committee No. 3, Finance and Administration, has studied the report of the Committee on Advisory to Selective Service for Physicians and Allied Specialists, as presented by Dr. J. Rocher Chappell, Chairman, and approves same. I move the report be adopted."

Motion seconded and carried.

Report of Committee on Advisory to Selective Service for Physicians and Allied Specialists

J. Rocher Chappell, *Chairman*

Submitted herewith is the report of the Florida Advisory Committee to Selective Service System for Physicians for the year 1951. Your committee wishes to submit the following statistical report regarding Special Registrants:

Total living physician registrants		1,345
Priority I	138	
Priority II	40	
Priority III	423	
Priority IV	744	
Classified by Selective Service Boards with advice from your committee		178
Priority I	138	
Priority II	40	
Selective service classification 1-A examined and available for military service		20
Priority I	12	
Priority II	8	
Selective Service classification 1-A not completely processed		4
Priority I	3	
Priority II	1	
Selective Service classification 1-C commissioned and on active duty		46
Priority I	41	
Priority II	5	
Selective Service classification 1-D commissioned and not on active duty		29
Priority I	25	
Priority II	4	
Selective Service classification 2-A deferred by Local Boards (declared essential by Advisory Committee)		38
Priority I	30	
Priority II	8	
Selective Service classification 3-A deferred by reason of hardship		2
Priority I	None	
Priority II	2	
Selective Service classification 4-F physically or mentally disqualified		39
Priority I	27	
Priority II	12	
Total Deceased		1
Priority I	1	

In filling special call No. 1 for physicians scheduled for delivery in July 1951, all priority I registrants who were born subsequent to December 31, 1922 were ordered. Official call was for five physicians of the first priority. Your committee wrote these five physicians two weeks prior to their date of induction, asking them to please volunteer for commissions. One week prior to their induction your committee sent telegrams to these five physicians asking them please to apply for commissions. All five physicians applied for and were given commissions and were not required to report for induction by the Selective Service Board. One special registrant, who was a transfer from the Georgia State Selective Service Board was delivered and inducted on August 22, 1951 at the induction station in Tampa, Florida.

During the year 1951 your committee processed 183 Naval Reserve Officers residing in the state of Florida:

Priority IV — available for military service	137
Priority IV — essential to the community	26
Priority III — available for military service	1
Priority III — essential to the community	2
Priority II — available for military service	14
Priority II — essential to the community	1
Priority I — available for military service	2

Your committee wishes to express its appreciation to the county committees of each medical society. Their work has been enormous and we have called upon them time and again for information regarding physicians living and practicing in their communities. Without their help and loyal cooperation the work could not have been done.

Respectfully submitted,
J. Rocher Chappell, *Chairman*

Dr. Rowlett: "Reference Committee No. 3, Finance and Administration, studied the report on the Emergency Medical Service Committee, as presented by its Chairman, Dr. James L. Borland, and approves the same. I move the report be adopted."

Motion seconded and carried.

Report of Committee on Emergency Medical Service

James L. Borland, *Chairman*

Most of the work on Civil Defense has been done on the local and county levels for the past year.

This committee has not been too active. Medical Supplements for the Civil Defense planning have been published.

This coming year this committee will have more work to do in the unification of the local plans.

Respectfully submitted,
James L. Borland, *Chairman*

Dr. Rowlett: "Reference Committee No. 3, Finance and Administration, approves the resolution on change of schedule for annual meetings of specialty groups presented by Orange County Medical Society, and, Mr. President, I move the resolution be adopted."

Motion seconded and carried.

Resolution

WHEREAS, Most of the special societies are holding meetings the weekend previous to the annual meeting of the Florida Medical Association, and

WHEREAS, Many of those members of these societies leave for home or other activities on the first day of the annual meeting, and

WHEREAS, This takes many of the outstanding men away from the Florida Medical Association scientific sessions, and

WHEREAS, The scientific sessions should be set up for the greatest benefit of each and every member of the Florida Medical Association,

THEREFORE BE IT RESOLVED, That the Board of Governors appoint a committee to consider this problem during the coming year and report to the 1953 session of the Florida House of Delegates.

Passed by Orange County Medical Society April 16, 1952.

Dr. Rowlett: "Reference Committee No. 3, Finance and Administration, approves the report of the Dade County Medical Association relative to the duties of the first vice president of the Florida Medical Association, and Mr. President, I move the adoption of the resolution."

Motion seconded and carried.

Resolution

BE IT RESOLVED BY THE DADE COUNTY MEDICAL ASSOCIATION MEMBERS CONVENED That the Dade County Medical Association recommends to the Florida Medical Association Board of Governors that the first vice president of the Florida Medical Association be assigned certain specific duties and responsibilities pertaining to activities of the Florida Medical Association and that they take the necessary steps to change the By-Laws and/or Constitution of the Florida Medical Association so as to make such selected duties and responsibilities obligatory to that office.

Passed by the Dade County Medical Association in Assembly convened on April 1, 1952.

Dr. Rowlett: "Reference Committee No. 3, Finance and Administration, has read the report of the Committee on Necrology by its Chairman, Dr. Joseph Halton, and moves that the same be published as printed, along with its supplementary report. I move its adoption."

Motion seconded and carried.

Report of Committee on Necrology

Joseph Halton, *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

Joseph H. Chiles, Orlando
Herbert W. Counts, Jacksonville
Lucien B. Dickerson, Clearwater
Horace R. Drew, Jacksonville
Robert B. Glenn, Jacksonville
George L. Hardgrave, Clarksville, Ark.
Everett E. Howard, Gainesville
Gerald W. Jones, Orlando
James B. Lowry, Lakeland
Joseph E. McGunagle, Miami
Leon H. Martin, Okeechobee
Homer J. Moore, Miami
Louis B. Mount, St. Petersburg
Robbins Nettles, Ocala
Ernest E. Nunnery, Everglades
James F. Pitman, Lake City
Jay A. Powell, West Palm Beach
Franklin W. Roush, Sr., St. Petersburg
Clarence M. Sandusky, Jacksonville
Selmer P. Smiseth, St. Petersburg
John A. Stanford, Fort Lauderdale
Joe I. Turberville, Century
John K. Turberville, Century
James E. Wallace, Jacksonville

Supplement

James A. Bradley, St. Petersburg
Harold F. McDuffie, Jacksonville
J. Randolph Perdue, Miami
Henry O. Snow, Tampa
Wm. R. Thomson, Miami
W. B. Hopkins, Tampa

When possible, obituaries have appeared in The Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we at this time stand for a moment of silence in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,
Joseph Halton, *Chairman*

Dr. Rowlett: "The last words to his wife by Peter Marshall, that great Chaplain of the United State Senate were: 'I'll see you in the morning.' Since we met here in this room 30 of our comrades have passed on to their eternal reward. I will ask Dr. Charles H. Daffin of our Necrology Committee to come forward and take a seat on the rostrum while I call off their names."

As each name was called, a white rose was placed in a vase by Dr. Daffin.

Dr. Rowlett: "Mr. President, in reverence to our departed comrades may we stand for a moment of silent prayer."

President Murphey: "As President of the Association I want to thank the members of the reference committees for a job well done."

President Murphey: "Is there any other unfinished business?"

The time being 11:25 a.m. the Chair declared a recess until 12:00 noon.

The President reconvened the House of Delegates at 12:00 noon, Wednesday, April 30, 1952.

President Murphey: "The House of Delgates will please come to order. The Chair recognizes Dr. Jelks."

Dr. Jelks: "One year ago this House of Delegates directed the officers to secure for presentation to Dr. Stewart Thompson a certificate of appreciation for his twenty-five years of continuous service. The value of his services in the growth and achievements of our organization is apparent wherever the Florida Medical Association is functioning. Especially do we older members know the good his serving 25 years has been to organized medicine in Florida.

"In trying to discover why Stewart has made himself so valuable to all of us, may it not be that consciously or unconsciously, he has desired most: first, wisdom to do what is best for the advancement of our Association and, second, friendship of its members? Evidently in achieving his first desire he early learned the truth:

> 'To know that which lies before us in daily life
> Is the prime wisdom.'
> Paradise Lost — Book 8 Milton

"His second desire has been a friendly comradeship with every member of the Florida Medical Association. Frequently he has expressed appreciation of this relationship as a necessity for his serving to the limit of his ability. He must believe:

> 'Friendship above all ties does bind the heart:
> And faith in friendship is the noblest part.'
> King Henry IV Earl of Orrery

"In striving for these two goals he not only has served us well but has made our friendship with him a precious thing.

"It is an honor, Stewart, to present to you this token of appreciation from the Florida Medical Association."

On behalf of the members of the Association, Dr. Jelks presented Dr. Thompson with a Certificate of Honor worded as follows:

CERTIFICATE OF HONOR

affectionately bestowed on

STEWART G. THOMPSON, D.P.H.

on behalf of the officers
and members of the

FLORIDA MEDICAL ASSOCIATION

in commemoration of a quarter
century of continuous and
unselfish service

1926-1951

/s/ David R. Murphey, Jr., M.D.
President

/s/ Samuel M. Day, M.D.
Secretary

Dr. Thompson: "I am sure I am not worthy but I deeply appreciate it."

President Murphey: "We will now have the election of officers of the Association. The Chair will appoint as tellers: Dr. Francis H. Langley, Dr. Russell B. Carson, Dr. George W. Morse."

The Chair recognized Dr. Louis M. Orr, II, Chairman of the Credentials Committee.

The roll was called by Dr. Orr.

President Murphey: "We have a quorum. Nominations for president-elect are now in order."

The Chair recognized Dr. V. Marklin Johnson from West Palm Beach.

Dr. Johnson: "Mr. President, members of the House of Delegates. Palm Beach County nominates for the office of president-elect a member of this Association who is deserving of its highest honor, having been a member of the Association for the past 26 years. He has served it well in many capacities. He is a modest man, and most of the facts which I relate to you concerning him have become known to me through association with him over a period of 21 years.

"He is a native of the state of Pennsylvania, having been born in Reynoldsville, Pa., Feb. 2, 1893.

"His medical career began upon graduation from the Johns Hopkins University School of Medicine at the age of 23. His early hospital training followed at Hartford Hospital, interning there 1916-1917. He then entered the Medical Corps of the Regular Army of the United States and, pursuing a career in radiology, graduated from the Army Medical School and the School of Roentgenology.

"There followed a tour of duty until 1922. He served at various posts and stations and filled such assignments as Surgeon, Fort Jay, New York, and as Chief of the X-ray Service at Walter Reed

Army General Hospital, Washington, D. C., and at Fitzsimons General Hospital in Denver.

"The following four years were spent in Spokane, Wash., pursuing the private practice of radiology and serving as assistant radiologist to the Sacred Heart Hospital. He was then a member of the Spokane County Medical Society and the Washington State Medical Association.

"He moved to Florida in 1926 and has been engaged in the private and hospital practice of radiology in the Palm Beach area ever since, serving as Radiologist to the Good Samaritan Hospital in the years 1926-1948 and to the St. Mary's Hospital from its time of organization to the present, except for the years 1942 to 1945; during those years he returned to active duty in the Army; he served at Ft. Bragg, N. C., as Chief Medical Examiner at the Armed Forces Induction Center, as Chief of the X-ray Service at the Regional Hospital, and later as Surgeon of its Personnel and Separation Center. He now holds the rank of Lt. Colonel, Retired, U. S. Army.

"He is married and has a daughter and a son.

"At home he is one of our leading citizens, active in civic and religious affairs. He is an outstanding Rotarian and has held many important positions in our community.

"I sincerely believe that the physicians of Palm Beach County consider him the most important member of our County Medical Society. He has held very office and is always called upon as final authority in matters pertaining to county or state medical affairs. He is a member of many medical organizations.

"Among others he is a Fellow of the American College of Physicians, a Fellow of the American College of Radiology, and a Fellow of the Academy International of Medicine. He is a Diplomate of the American Board of Radiology, a member of the American Roentgen Ray Society, the Radiological Society of North America, the Florida Radiological Society, of which he is a charter member and past-president, the Association of Military Surgeons, U. S., the Association for the Study of Neoplastic Diseases, the Southern Medical Association, and the American Geriatric Society.

"As a man, he is sincere, devout of purpose, and although a perfectionist, can always appreciate the practical. As a member of his specialty group he has held high office and is well known to all of his colleagues. As a member of the Florida Medical Association he has served actively in many capacities. Last year, you will recall his efficient services as Chairman of the Scientific Work Committee. At present he is a member of that committee, a member of the Credentials Committee, and your first vice president.

"I consider it indeed an honor to have been chosen by the Palm Beach County Medical Delegation to nominate Frederick K. Herpel for the office of president-elect."

President Murphey: "Dr. Herpel has been nominated."

The Chair recognized Dr. Samuel G. Hibbs.

Dr. Hibbs: "Dr. Johnson has left little for me to say. But may I tell you that in the past year I have gotten to know Frederick Herpel. I have found that each moment I have spent with him caused me to feel more kindly and to recognize that he is a man who can carry on the fine work that the Florida Medical Association has been doing in the past year. He is a man such that few can measure up to his stature. I deem it a sincere privilege to second the nomination of Dr. Frederick K. Herpel."

President Murphey: "Thank you, Dr. Hibbs. Are there any other nominations?"

Dr. Duncan T. McEwan: "I move that the nominations be closed and the secretary cast the ballot for the election of Dr. Frederick K. Herpel."

Motion seconded and carried.

President Murphey: "Will Dr. Johnson and Dr. Dell escort Dr. Herpel to the rostrum?"

Dr. Herpel: "President Dave, members of the House of Delegates, and guests. I do not have a speech of acceptance, strange as it may seem. I have always been suspicious of congratulations before the election actually occurs, because looking back I have seen some peculiar things happen. I should be very remiss if I did not express my deep appreciation for the honor which you have conferred upon me. I will do everything in my power to advance the status of medicine in the state of Florida. I shall do everything possible to increase the stature of physicians in city, state and nation. If there is to be any house cleaning we must do it ourselves. Each one of us as physicians has it in his power to eliminate all dissension between physician and patient, between public and hospital, hospital and physician. There is no sense as I see it for permitting misunderstandings on local, county, state, and national levels. We have it in our power to correct those things for which

we originally exist. We have no reason for being organized as physicians unless we serve the public because, primarily, the patient is our first consideration.

"We are interested in the preservation of the practice of medicine and have the right to be so concerned. The patient must come first. I assure you again that I very much appreciate the honor of this act, and if my term will be successful it will be because of the cooperation of each one of you in the Association and Woman's Auxiliary and others who are interested in the advancement of medicine in the state of Florida. Thank you very much."

President Murphey: "Nominations are now open for first vice president."

Dr. Meredith Mallory, Sr.: "Mr President, members of the House of Delegates, members of the Association and guests. I have the honor today of presenting the name of one of our outstanding members in nomination for the office of first vice president. He came near to being a Florida cracker. Coming from Ohio, he attended public schools in Florida. He received his premedical degree from Johns Hopkins. He served during World War II in France and Germany and was released to inactive duty in the rank of Lieutenant Colonel. He has been president of his county medical society, a member of the Association's Board of Governors and district chairman for the Florida Medical Committee for Better Government. It gives me a great deal of pleasure to present to you Dr. Francis H. Langley."

President Murphey: "Dr. Langley has been nominated for the office of first vice president."

Dr. Chas. W. Bartlett: "Mr. President, members of the House of Delegates, it is indeed with pleasure that I come to second the nomination of Dr. Langley of Pinellas. I hold Dr. Langley high in esteem, not only as a neighbor, but as a gentleman and a scholar."

President Murphey: "Are there any other nominations?"

Dr. Herschel G. Cole: "I move the nominations be closed and the secretary cast the ballot for the election of Dr. Langley as first vice president."

Motion seconded and carried.

President Murphey: "You have elected Dr. Francis H. Langley your first vice president."

President Murphey: "The Chair will entertain nominations for the office of second vice president."

Dr. Leigh F. Robinson: "I would like to nominate Dr. Russell B. Carson of Fort Lauderdale."

Nomination of Dr. Carson was seconded by Dr. Robert B. McIver.

Dr. Vale D. Stone: "I would like to submit the name of Dr. Erasmus B. Hardee for the office of second vice president."

President Murphey: "Are there any other nominations?"

Dr. Samuel G. Hibbs: "I move the nominations be closed."

Motion seconded and carried.

The Chair ruled that a secret ballot was in order and appointed Dr. Francis T. Holland to replace Dr. Carson as teller.

The secretary, Dr. Day, announced the results of the ballot: Dr. Russell B. Carson, 45; Dr. Erasmus B. Hardee, 53.

President Murphey: "Dr. Erasmus B. Hardee having received a majority of the votes cast has been elected second vice president."

President Murphey: "Nominations are now in order for the office of third vice president."

Dr. Frazier J. Payton: "I would like to nominate Dr. H. Quillian Jones."

Dr. Raymond R. Killinger: "I second the nomination."

Dr. Arthur H. Weiland: "I move the nominations be closed and the secretary cast the ballot for the election of Dr. H. Quillian Jones."

Motion seconded and carried.

President Murphey: "Dr. H. Quillian Jones has been elected third vice president."

President Murphey: "Nominations are now in order for the office of secretary-treasurer."

Dr. William M. Rowlett: "Mr. President, members of the House of Delegates, and guests. Years of service have proven that the welfare of our Association is best served by having as secretary a man that resides in the same city in which our headquarters are located. I nominate Dr. Samuel M. Day."

Dr. Arthur H. Weiland: "Mr. President, members of the House of Delegates. This office is a personal one; first you must find a man who is willing to take that sort of a job; second, one who has the time to devote to the job; third, a man

who is capable of doing a good job, and has sufficient experience to do a good job. The man that I have in mind fits all of these qualifications. He is willing and has the time. It has been my observation that in a similar capacity he has done an excellent job. I desire to place before this group the name of Dr. Ralph S. Sappenfield in nomination for the office of secretary-treasurer."

President Murphey: "Dr. Sappenfield has been nominated."

Dr. Jere W. Annis: "Gentlemen: a year ago I had the very great privilege of nominating Dr. Sam Day for the office of secretary-treasurer. I believe that the distant view of the situation from a year hence has justified the confidence we had at that time, that he would be a good secretary. There is only one job that I want in this Association and that is to keep seconding Dr. Sam Day's nominations for the next 15 years."

President Murphey: "Are there any other nominations?"

It was moved that the nominations be closed.

Motion seconded and carried.

President Murphey: "Dr. Edward R. Annis, will you substitute for the incumbent secretary-treasurer at the blackboard please?"

Dr. Annis announced that the tellers' results of the ballot were: Dr. Samuel M. Day, 60; Dr. Ralph S. Sappenfield, 40.

President Murphey: "Dr. Day has been elected secretary-treasurer."

President Murphey: "The Chair will entertain nominations for Editor of The Journal."

Dr. William C. Roberts: "Mr. President, members of the House of Delegates, and guests. Sam Day has been stuck for another year. I know a fellow who has been stuck for 30 years. Beginning in 1925 we needed an editor of The Journal. We had 250 members. Those 250 members all called upon this man to be the editor. This man has given continuously of his time. If you attended any of the district meetings this year you heard the breakdown from the editor about your Journal. He manifested time and time again that it was *your* Journal. Our Journal bats high with other state Journals. If you think the rest of the nation approves our Journal then allow the present editor to keep on getting the stamp of approval. I nominate Dr. Shaler Richardson to continue as editor."

President Murphey: "Dr. Richardson has been nominated."

Dr. John D. Milton: "I move the nominations be closed and the secretary cast the ballot for the election of Dr. Shaler Richardson."

Motion carried.

The Chair declared Dr. Richardson elected editor of The Journal.

President Murphey: "The moment which I have been looking forward to for 12 months has arrived. Will Dr. James L. Borland and Dr. Herbert E. White escort our new president, Dr. McIver, to the rostrum?"

Dr. McIver was escorted to the rostrum.

Dr. Murphey: "It is a pleasure for me to turn the helm of this Association into such capable hands. I sincerely hope and believe that your administration will be one of the best we have ever had."

President McIver: "Thank you, Dr. Murphey, for your very kind introduction and your good wishes for our administration. You have been one of the very youngest presidents of this Association and, as is generally conceded, one of the very best. It now becomes my pleasant duty to bestow on Dr. David R. Murphey, Jr., this past president's pin and official recognition, a Certificate of Honor, from the Association commending your services as its chief official."

Dr. Murphey: "Members of the Florida Medical Association and guests. The English language is inadequate, or my knowledge of the English language is inadequate, to express my feelings in receiving this button and certificate, and I will always remember that the accomplishments of the past year were the results of my committees who worked so diligently for this Association. I appreciate your assistance. You are all aware of the years that we spend in school to become a physician. As I sit here today and look out in the audience I see a teacher whom I believe has had more influence on my life and thinking than any teacher I have ever had. She was my teacher in the sixth and seventh grades in grammar school. I would like at this time to recognize Miss Patty B. King."

Miss King stood and received hearty applause.

President McIver: "For the first time, our Association has presented to the incoming President the authority of office in the form of a personal gavel, to be used during his year of service and to be his own thereafter. This beautiful gavel, fashioned from durable hardwood and encircled

by a solid silver band, appropriately engraved, will be a constant reminder of the sturdy competence of our organization and the sterling character of its immediate past president.

"The Florida Medical Association, through its Board of Governors, has not only bestowed this handsome gavel upon the incoming president, but has also awarded a like gavel to each living past president. It is now a happy occasion as the Chair presents these awards: First to the oldest living past president, elected in 1919, inaugurated in 1920, Dr. William E. Ross, of Jacksonville, who may care to say a few words."

Dr. Ross: "Mr. President, members and guests. This to me is a great day. I see hundreds of new faces and a few old-timers; among the latter John McEwan with whom I sat at the dinner last evening. I wish you success in the future."

President McIver: "Thank you, Bill. You were the presiding officer when I attended my first meeting (1920).

"And now, Dr. H. Marshall Taylor of Jacksonville, 1923, who could not attend. I will ask Dr. Dekle Taylor to accept the gavel for his father.

"Dr. John C. Vinson, Fort Myers, 1924, sent in his regrets. Dr. Stewart Thompson will forward his gavel with an appropriate note.

"Dr. John S. McEwan of Orlando, 1925. Dr. H. Mason Smith of Tampa, 1926, is unable to be present on account of illness. Dr. William Rowlett will accept this gavel and personally present it to Dr. Mason Smith.

"Dr. John A. Simmons of Arcadia, 1927. Dr. Frederick J. Waas of Jacksonville, 1928, is unable to be present. The Chair will appoint Dr. Sam Day to accept this gavel for Dr. Waas.

"Dr. Julius C. Davis of Quincy, 1930. Dr. William M. Rowlett of Tampa, 1933. Dr. Homer L. Pearson, Jr., of Miami, 1934. Dr. Herbert L. Bryans of Pensacola, 1935.

"Dr. Orion O. Feaster, formerly of St. Petersburg, 1936. Dr. Thompson will forward this gavel to his present address.

"Dr. Edward Jelks of Jacksonville, 1937. Dr. W. Henry Spiers, formerly of Orlando, 1938. Dr. Leigh F. Robinson of Fort Lauderdale, 1939. Dr. Walter C. Jones of Miami, 1941.

"Dr. Eugene G. Peek, Sr., of Ocala, 1943. The Chair will request Dr. Eugene G. Peek, Jr., to come forward and accept this gavel in the name of his father.

"Dr. John R. Boling of Tampa, 1944 and 1945. Dr. Boling served two consecutive years during World War II. He is detained by illness. The Chair will appoint Dr. David Murphey to present this gavel in Tampa.

"Dr. Shaler Richardson of Jacksonville, 1946. Dr. William C. Thomas, Sr., of Gainesville, 1947. Dr. Joseph S. Stewart of Miami, 1948. Dr. Walter C. Payne of Pensacola, 1949. Dr. Herbert E. White of St. Augustine, 1950. Dr. David R. Murphey, Jr., of Tampa, 1951."

President McIver: "Are there any announcements?"

President McIver: "Immediately following adjournment there will be a meeting of the Board of Governors in Room 544. The re-elected secretary-treasurer, the newly elected president-elect and Dr. John D. Milton of Miami will please be in attendance."

There being no further business, on motion from the floor, duly seconded and carried, the House of Delegates adjourned, sine die, at 1:15 p.m.

THE SEVENTY-NINTH ANNUAL CONVENTION
of the
FLORIDA MEDICAL ASSOCIATION
HOLLYWOOD BEACH HOTEL APRIL 26-29, 1953

SCIENTIFIC ASSEMBLIES

First Scientific Assembly

The first Scientific Assembly convened at 9:45 a.m., Monday, April 28, in the Sun Room with Dr. James N. Patterson of Tampa presiding. The following papers were read and discussed:

"Exchange Transfusion in Erythroblastosis Fetalis," James J. Griffitts, Miami.

"Management of an Outbreak of Anthrax," Scottie J. Wilson, Fort Lauderdale.

"Present Status of Anticoagulant Therapy in Coronary Artery Disease," E. Sterling Nichol, Miami.

"Experiences with the Therapeutic Use of a Long Acting Corticotrophic Preparation," Carlos P. Lamar, Miami.

"Salt Depletion Syndrome," George F. Schmitt, Jr., Miami.

Second Scientific Assembly

The second Scientific Assembly convened at 2:00 p.m., Monday, April 28, in the Sun Room with Dr. Jere W. Annis of Lakeland presiding.

The following papers were read and discussed:

"Dermatologic Dangers of Sunlight," Morris Waisman, Tampa.

"Coronary Disease of the Inner Ear: The Vascular Origin of Vertigo and Deafness," Jerome A. Hilger, St. Paul.

"New Method of Feeding the Critical and the Chronically Ill Surgical Patients," Donald W. Smith, Miami.

"The Use of Artificial Prothesis in the Neck of the Femur," Herschel G. Cole, Tampa, and Arthur H. Weiland, Coral Gables.

"Surgery of Parotid Tumors," Wilbur C. Sumner, Jacksonville.

Third Scientific Assembly

The third Scientific Assembly convened at 2:30 p.m., Tuesday, April 29, in the Sun Room with Dr. Frederick K. Herpel of West Palm Beach presiding. The entire assembly was given over to a Symposium on Hypersplenism, with Steven O. Schwartz, Director of Hematology, The Hektoen Institute for Medical Research, Cook County Hospital, Chicago, as moderator. The following papers were read:

"Hemolytic Anemias," Sherman R. Kaplan, Miami Beach.

"Thrombocytopenic Purpura," O. Whitmore Burtner, Miami.

"Agranulocytosis and Miscellaneous Manifestations," William W. Trice, Jr., Tampa.

"Roentgenologic Diagnosis," J. Maxey Dell, Jr., Gainesville.

"Technical Aspects of Splenectomy, Location of Accessory Spleens," George W. Morse, Pensacola.

"Pathology of Hypersplenism," V. Marklin Johnson, West Palm Beach.

Following a summary by Dr. Schwartz, there was an open discussion.

Fourth Scientific Assembly

The fourth Scientific Assembly convened at 9:00 a.m., Wednesday, April 30, in the Sun Room with Dr. James L. Borland of Jacksonville presiding. The following papers were read and discussed:

"Mental Deficiency," William L. Musser, Keystone Heights.

"Pernicious Anemia of Pregnancy," Herbert B. Lott, Tampa. (Read by Dr. Curtis C. Rorebeck of Tampa due to the unavoidable absence of Dr. Lott.)

Scientific Motion Pictures

Scientific motion pictures were shown starting at 9:00 a.m., Tuesday, April 29, in the Theatre with Dr. Jere W. Annis of Lakeland presiding. The following films were shown:

1. "The Significance of Chronic Hoarseness," and 2. "Surgery of the Larynx and Trachea," Nathaniel M. Levin, Miami.

"The Commoner Conditions Involving the Esophagus," Nathaniel M. Levin, Miami.

"Congenital Hip Displasia," Theodore Norley, West Palm Beach.

"Cataract Extraction by Erisophake," James R. Nieder, Delray Beach.

"Gastrointestinal Cancer: The Problems of Early Diagnosis," Lorenzo L. Parks, Secretary, Florida Cancer Council, Jacksonville.

REGISTRATION

The registration for the Seventy-Eighth Annual Meeting at Hollywood surpassed that of any previous convention of the Association. The total number registered was 1,621 persons. The registrants included 806 members of the Association, 158 visiting physicians, 7 other guests, 444 members and guests of the Woman's Auxiliary, and 206 representatives of exhibiting firms. There were 23 other states and Panama represented.

Registration List

Officers

David R. Murphey, Jr., President.....Tampa
Robert B. McIver, President-elect.....Jacksonville
Frederick K. Herpel, 1st Vice Pres.....West Palm Beach
Chas. J. Collins, 2nd Vice Pres.....Orlando
Edward R. Annis, 3rd Vice-Pres.....Miami
Samuel M. Day, Sec'y-Treas.....Jacksonville
Shaler Richardson, Editor.....Jacksonville
Stewart G. Thompson, Managing Director.....Jacksonville

Members

APALACHICOLA: Terry Bird, Photis J. Nichols. APOPKA: Thomas E. McBride. ARCADIA: Charles H. Kirkpatrick, Gordon H. McSwain, John A. Simmons. AVON PARK: Hubert W. Coleman, Donald C. Hartwell. BARTOW: Milo H. Holden, William F. Peacock. BELLE GLADE: Eugene E. Christian (Col.), Ralph L. Pipes. BOYNTON BEACH: Nathaniel M. Weems. BRADENTON: Millard P. Quillian, William D. Sugg, Willett E. Wentzel. BRANFORD: Edward G. Haskell, Jr. BROOKSVILLE: S. Carnes Harvard. BUSHNELL: Karl T. Humes.

CHATTAHOOCHEE: William D. Rogers. CHIPLEY: Bayllye W. Dalton, Oswald A. Holzer. CLEARWATER: M. Eldridge Black, Julio J. Guerra, V. LeRoy Hagan, Everett M. Harrison, Francis G. Hoare, Claude G. Hooten, Jr., George H. Schoetker, M. Crego Smith, George C. Tillman, Robert M. Wolff. COCOA: Thomas C. Kenaston, Walter C. Page, Charles E. Russell. CORAL GABLES: John C. Ajac, A. Daniel Amerise, Gunnard J. Antell, Charles R. Burbacher, Henry H. Caffee, Jack Q. Cleveland, Philip J. Chastain, J. Kenneth Cole, Franklin J. Evans, Richard C. Forman, Edward E. Hodsdon, R. Spencer Howell, Charles F. Hudson, Robert P. Keiser, Gordon J. McCurdy, C. Howard McDevitt, Jr., Wesley S. Nock, Frederick P. Poppe, Warren W. Quillian, T. D. Sandberg, William P. Smith, Rollin D. Thompson, Franklyn E. Verdon, Karl W. Vetter, William L. Wagener, Jr., Arthur H. Weiland, Hillard W. Willis, Bernard Yesner.

DANIA: Fred E. Brammer. DAYTONA BEACH: George P. Beach, James W. Clower, Jr., Hugh Crawford, C. Robert DeArmas, David W. Goddard, George M. Green, William L. Jennings, Herbert A. King, Eric H. Lenholt, Edward P. Madden, James D. Moffett, Jr., Achille A. Monaco, John A. O'Donnell, Howard W. Reed, Joseph H. Rutter, Morris B. Seltzer, Stanford S. Setnor, Ludo von Meysenbug, J. Richard West. DeFUNIAK SPRINGS: William D. Cawthon. DeLAND: Frank Valentine. DELRAY BEACH: Martin E. Buerk, Graham W. King, Jr., James R. Nieder, Charles A. Robinson. DUNEDIN: John A. Mease, Jr., Walter H. Winchester. EAU GALLIE: Jack T. Bechtel. EUSTIS: C. McK. Tyre. FERNANDINA BEACH: Benjamin F. Dickens. FOLEY: Walter J. Baker.

FORT LAUDERDALE: Norris M. Beasley, Robert E. Blount, Oliver C. Brown, Mark Butler, Russell B. Carson, Eugene C. Chamberlain, Alfred E. Cronkite, Frank Denniston, Burns A. Dobbins, Jr., Frederick J. Driscoll, Robert L. Elliston, Roland F. Fisher, Donald H. Gahagen, Walter J. Glenn, Jr., George Hamerick, Jr., Anne L. Hendricks, Thomas F. Huey, Jr., Paul W. Hughes, Garland M. Johnson, M. Austin Lovejoy, Lloyd U. Lumpkin, Thomas L. McKee, Richard A. Mills, Henry J. Peavy, Sr., William K. Peck, Claus A. Peterson, Francis D. Pierce, Raymond M. Price, George M. Rhodes, Jr., Thomas L. Roberts, Jr., Leigh F. Robinson, Vincent V. Smith, Curtis H. Sory, Alva R. Taylor, Chas. L. Wadsworth, James M. Weaver, William D. Wells, S. Elliott Wilson, Scottie J. Wilson, Charles J. Zinn.

FORT MYERS: William H. Grace, Joseph L. Selden. FORT PIERCE: Russell L. Counts, Hugh B. Goodwin, Jr., Adrian M. Sample, Richard F. Sinnott, Lester L. Whiddon. GAINESVILLE: Edwin H. Andrews, Henry J. Babers, Jr., F. Emory Bell, J. Maxey Dell, Jr., Frank M. Hall, Albert G. Love, IV, James M. McClamroch, John E. Maines, Jr., Walter E. Murphree, George H. Putnam, Thomas A. Snow, William C. Thomas, Sr., I. Irving Weintraub. GRACEVILLE: Redden L. Miller. GROVELAND: John D. Bloom. HAVANA: James W. Sapp. HOLLYWOOD: Thomas S. Adams, Dale T. Anstine, Alexander H. Bluestone, Arthur B. Connor, Robert H. Farringer, Robert R. Harriss, John R. Hege, Jr., Royle B. Klinkenberg, Elbert McLaury, Bernard Milloff, Louis J. Novak, Randall W. Snow, George P. Sorvas.

JACKSONVILLE: Donald M. Baldwin, Cornelius A. Bird, John B. Black, James L. Borland, Frederick H. Bowen, Jack H. Bowen, Joseph Canipelli, Turner Z. Cason, Lee E. Bransford, Jr., William H. Brooks, Robert J. Brown, George A. Dame, J. K. David, Jr., Lucien Y. Dyrenforth, Joseph A. J. Farrington, Joel Fleet, Frank L. Fort, Lawrence E. Geeslin, A. Judson Graves, Sidney Halpern, Karl B. Hanson, Albert V. Hardy, O. E. Harrell, William G. Harris, John W. Hayes, Charles F. Henley, Luther W. Holloway, Victor A. Hughes, Floyd K. Hurt, Thomas M. Irwin, Ivan Isaacs, Edward Jelks, Raymond R. Killinger, F. Gordon King, Raymond H. King, Samuel R. Lamb, James C. Lanier, Elmer E. Leitner, Camillus S. L'Engle, Thomas H. Lipscomb, Samuel S. Lombardo, John F. Lovejoy, Bernard J. McCloskey, William H. McCullagh, Reuben L. McDaniel, John H. Mitchell, Matthew E. Morrow, Jr., Thaddeus Moseley, III, Nelson A. Murray, Melvin Newman, Aaron Z. Oberdorfer, G. Frederick Oetjen, Lorenzo L. Parks, Frances E. M. Read, Ferdinand Richards, Geo. W. Richardson, Thomas G. Ritch, Wade S. Rizk, C. Burling Roesch, W. W. Rogers, Clarence D. Rollins, Mason Romaine, III, William E. Ross, Louis M. Sales, Richard G. Skinner, Jr., Lauren M. Sompayrac, Wilson T. Sowder, Walker Stamps, Wilbur C. Sumner, G. Dekle Taylor, H. Marshall Taylor, J. Champneys Taylor, Richard P. Thompson, Frederick J. Waas, Leo M. Wachtel, Jr., Edward C. Watt, Samuel M. Wells, Ashbel C. Williams, J. Frank Wilson.

KEYSTONE HEIGHTS: William L. Musser. KEY WEST: Ralph Herz. LAKE BUTLER: Charles F. McKay. LAKE CITY: Laurie J. Arnold, Jr., Thomas H. Bates, Benjamin Steinberg.

LAKELAND: Jere W. Annis, James R. Boulware, Jr., John E. Daughtrey, Fred S. Gachet, Ralph B. Hanahan, Marion W. Hester, Everett S. King, T. Hugh Roberts, James T. Shelden, John W. Williams. LAKE WALES: Edward C. Burns, Jr., Joseph L. Kinzie, Harry F. Rolfes. LAKEWOOD: Arthur G. Williams, Sr. LAKE WORTH: Sidney Davidson, Carl M. Pults, Alva L. Rowe, A. Scott Turk, Edward W. Wood.

LEESBURG: Marion B. O'Kelley. LIVE OAK: John N. Sims, Sr. MACCLENNY: John E. Watson. MANATEE: Blake M. Lancaster. MARIANNA: Daniel A. McKinnon, Francis M. Watson. MELBOURNE: Theodore J. Kaminski, Isabel Roberts, James A. Sewell, Arthur C. Tedford.

MIAMI: Julius Alexander, Lassar Alexander, Ralph F. Allen, James L. Anderson, Samuel Aronovitz, William G. Aten, Jr., George C. Austin, Hubert A. Barge, William J. Barge, Ernest R. Barnett, Harry E. Beller, Morris H. Blau, Maurice Blinski, Abraham Bolker, David Brezin, Andrew G. Brown, Earlsworth C. Brunner, John E. Burch, O. Whitmore Burtner, Orlon V. Carr, Jr., Turner E. Cate, Silas E. Chambers, Reuben B. Chrisman, Jr., George D. Conger, Francis N. Cooke, Maurice P. Cooper, Milton M. Coplan, Vincent P. Corso, Joseph H. Crawley, Edward W. Cullipher, DeWitt C. Daughtry, David Davidson, Carl H. Davis, Robert F. Dickey, John W. Dix, Percy L. Dodge, L. Washington Dowlen, Otto S. Dowlen, Adoph E. Drexel, Carl E. Dunaway, John G. DuPuis, Maurice I. Edelman, Herbert Eichert, Howard K. Edwards, Wm. H. Ellis, Bruce M. Esplin, Raymond L. Evans, R. Marshall Faver, George Ferre, James E. Fischer, Marvin G. Flannery, Richard M. Fleming, M. Jay Flipse, Roger J. Forastiere, Forrest H. Foreman, Edward F. Fox, Tom R. Gammage, Francis W. Glenn, Thomas S. Gowin, J. Raymond Graves, James J. Griffitts, Dale L. Groom, Young L. Hall, Jr., Morton M. Halpern, Robert M. Harris, Winston F. Harrison, W. Tracy Haverfield, Ella M. Hediger, James W. Holmes, William M. Howdon, William C. Hutchison, Ralph W. Jack, Milton B. Jacobson, Joseph T. Jana, Jr., Paul S. Jarrett, Valentine E. Jenkins, Edwin J. Jensen, Walter C. Jones, Arthur L. Juers, Bernard A. Kiminski, Ralph E. Kirsch, Erna K. Klass, Morris E. Kuckku, Alexander Kushner, Carlos P. Lamar, William T. Lanier, George W. Lawson, Robert M. Lee, Louis Lemberg, Alfred G. Levin, Nathaniel M. Levin, Simon M. Lipton, Wm. D. Lithgow, A. Buist Litterer, Joseph Lomax, Manuel C. Lores, John J. McAndrew, E. Norton McKenzie, Jack A. McKenzie, Wm. W. McKibben, John V. McMackin, Plumer J. Manson, Stanley Margoshes, Donald F. Marion, Isidore Marx, John H. Mason, Jr., Lawrence R. Medoff, Matthias P. Meehan, James H. Mendel, Sr., James H. Mendel, Jr., Claude G. Mentzer, Robert F. Mikell, John D. Milton, Leon H. Mims, Jr., C. Russell Morgan, Jr., Elwin G. Neal, E. Sterling Nichol, Russell K. Nuzum, Benjamin G. Oren, Samuel W. Page, Jr., Frazier J. Payton, S. Joseph Pearlman, Colquitt Pearson, Homer L. Pearson, Jr., Nelson T. Pearson, Kenneth Phillips, Roland F. Phillips, Robert C. Piper, Benjamin G. Pollock, Edwin P. Preston, James H. Putman, Gerard Raap, Harold Rand, Jack O. W. Rash, Homer A. Reese, Phillipp R. Rezek, John R. Richardson, Samuel J. Roberts, George W. Robertson, III, Charles Rosenfeld, Manning J. Rosnick, Ruth W. Rumsey, Lyle W. Russell, Thomas N. Ryon, Walter W. Sackett, Jr., S. Marion Salley, Wiley M. Sams, Ralph S. Sappenfield, Milton S. Saslaw, Chaffee A. Scarborough, George F. Schmitt, Jr., Manuel A. Schofman, Joseph W. Scott, C. Kirby Smith, Donald W. Smith, John W. Snyder, Donald G. Stannus, Franz H. Stewart, Joseph S. Stewart, Richard F. Stover, William M. Straight, Richard E. Strain, Kelly C. Thomas, Henry L. Tippins, Martiele Turner, Ferdinand A. Vogt, Isaac N. Weinkle, Robert C. Welsh, Lynn W. Whelchel, Kenneth S. Whitmer, William Wickman, Edward H. Williams, George Williams, Jr., Arthur W. Wood, Jr., Frank M. Woods, Leo S. Wool, Scheffel H. Wright, Meyer Yanowitz, Corren P. Youmans, Iva C. Youmans, Leo A. Zuckerman.

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PAHOKEE: Chas. E. Creel, Ernest C. Johnson, Jr. PALATKA: Lawrence G. Hebel.

PALM BEACH: John H. R. Dyett (Col.), Joseph Feldman, Alfred F. Henderson, Russell D. D. Hoover, Oscar L. Kelley, Fred E. Manulis, S. Richard Ombres, Walter G. Robinson, Bailey B. Sory, Jr., James R. Sory, Joseph R. West, Robert Y. Wheelihan.

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QUINCY: Julius C. Davis, Taylor W. Griffin, George H. Massey, J. Lloyd Massey. RIVIERA BEACH: Frank M. Hewson, Jr. ST. AUGUSTINE: Charles C. Grace, S. Raymond Cafaro, Vernon A. Lockwood, Herbert E. White. ST. CLOUD: Robert G. Wood. ST. PETERSBURG: Arnold S. Anderson, Clyde O. Anderson, Grover W. Austin, Walter H. Bailey, Bernard T. Bell, Curtis W. Bowman, John R. Butter, John H. Cordes, Jr., William M. Davis, Luverne H. Domeier, Ira C. Evans, Cornelius S. Franckle, Albert R. Frederick, N. Worth Gable, Dean W. Hart, George F. Hieber, Frederick C. Knight, Francis H. Langley, Norval M. Marr, Robert B. Mertz, Alvin L. Mills, James M. Neill, Orville N. Nelson, Harrison G. Palmer, Joseph W. Pilkington, Edward V. Pollard, John P. Rowell, J. Braden Quicksall, Richard Reeser, Jr., H. Milton Rogers, Franklin W. Roush, Jr., Paul B. Stewart, Benjamin H. Sullivan, Rowland E. Wood.

SANFORD: Thomas F. McDaniel, Frank L. Quillman. SARASOTA: John M. Butcher, Michael A. DiCosola, Frederick D. Droege, A. Lamar Matthews, Jr., Henry G. Morton, Sherrel D. Patton, Karl R. Rolls, William A. Shannon, Thomas H. Wallace, Millard B. White, Reaves A. Wilson. SEBRING: Zaven M. Seron, Howard V. Weems, Sr. STUART: Walter F. Davey. TALLAHASSEE: Edson J. Andrews, G. Wilmot Brown, Jr., Paul J.

Coughlin, Francis T. Holland, John A. Lauer, Jr., George S. Palmer, James H. Pound. TAVARES: James R. Hanson. VENICE: Samuel E. Kaplan, Talmadge S. Thompson. VERO BEACH: John P. Gifford, Erasmus B. Hardee, P. T. McClellan, James C. Roberston.

TAMPA: Samuel H. Adams, Chadbourne A. Andrews, Chas. W. Bartlett, Arthur R. Beyer, William C. Blake, Ernest R. Bourkard, Harold O. Brown, Leffie M. Carlton, Jr., Harold Carron, Frank V. Chappell, C. Frank Chunn, Herschel G. Cole, Lewis T. Corum, James T. Cowart, Joshua C. Dickinson, Thomas M. Edwards, Oren A. Ellingson, J. Brown Farrior, Celestino G. Fernandez, Gaetano C. Ferrante, Sherman B. Forbes, Eugene S. Gilmer, Chas. McC. Gray, James C. Griffin, Donald W. Hedrick, John S. Helms, Jr., Samuel G. Hibbs, Richard S. Hodes, Arthur R. Knauf, Blackburn W. Lowry, Paul J. McCloskey, Myron L. McEachern, Thomas E. McKell, Alfonso F. Massaro, Eugene B. Maxwell, Frank C. Metzger, Joseph A. Minardi, Julien C. Pate, Jr., James N. Patterson, Anthony P. Perzia, William M. Rowlett, Joseph D. Scolaro, Hawley H. Seiler, Edward F. Shaver, Marshall E. Smith, Philip L. Smoak, Wray D. Storey, Harold Sutker, Joseph W. Taylor, Sr., Joseph N. Torretta, William W. Trice, Jr., Mason Trupp, Morris Waisman, Arthur J. Wallace, Homer H. Whitney, Wesley W. Wilson, James A. Winslow, Jr., Luther H. Zick.

WEST PALM BEACH: Willard F. Ande, James R. Anderson, Robert V. Artola, R. Henry Baldwin, Harry E. Bierley, William E. Bippus, Edwin W. Brown, John F. Chapman, Joseph J. Daversa, George M. Dawson, Matthew N. DePasquale, C. Jennings Derrick, Gerald M. DeWoody, S. Ward Fleming, William H. Gardner, W. Wellington George, Richard S. Gill, Charles McD. Harris, Jr., V. Marklin Johnson, Oliver L. Jones, Lawrence R. Leviton, R. Gaylord Lewis, W. Ambrose McGee, Samuel A. Manalan, David W. Martin, Lloyd J. Netto, Walter R. Newbern, David A. Newman, Theodore Norley, Ralph M. Overstreet, Jr., Cecil M. Peek, Raymond R. Preefer, Atwell B. Pride (Col.), Herman G. Rose, Raymond S. Roy, Lauchlin M. Rozier, W. Lawson Shackelford, Murray D. Sigman, W. Henry Spiers, Younger A. Staton, Edgar W. Stephens, Jr., Vale D. Stone, Laurie R. Teasdale, Wm. E. Van Landingham, Harry A. Wakefield, William H. Weems.

WINTER GARDEN: Albert H. Gleason. WINTER HAVEN: Ivan W. Gessler, Robert J. Jahn, Henry F. Keiber, William T. Steele. WINTER PARK: Henry J. Wiser.

MINNESOTA — ROCHESTER: M. Eugene Flipse.

Visiting Doctors

BRADENTON: Harvey C. Pauley. CORAL GABLES: E. Hampton Bryson, R. N. Davis, Jim S. Jewett, Joseph R. Morrow, Jack Reiss, John M. Rumball. DUNEDIN: James O. Norton. FORT LAUDERDALE: Ella M. A. Enlows, Richard L. Foster, Thos. H. D. Griffitts, Robert U. Moersch, Calvin H. Shirley, (Col.), Willard M. Taylor. HOLLYWOOD: Manuel G. Carmona, Bertram J. Frankel, Edward J. Folmer, Russell R. Hippensteel, Samuel J. Hodkin, Charlotte Mason, Jacob A. Rosof, Bernard B. Seltzer, Samuel Tilles. HOMESTEAD: Henry S. Rubin. INVERNESS: John S. Neill. JACKSONVILLE: Leslie R. Adams, Joseph W. Eversole, Emmet F. Ferguson, Jr., J. Ketchum, Amelia B. Sheftall, Edward R. Smith, W. A. Walter, James L. Wardlaw, Jr. LANTANA: John E. Costello, Ivan C. Schmidt. MACDILL A. F. BASE: J. Ed Campbell, Jr. MIAMI: J. Ernest Ayre, Walter L. Baumann, Thomas C. Burger, Fernando Capmany, Chester Cassel, David L. Crane, Geo. Gittelson, Francisco A. Hernandez, Claude D. Holmes, Jr., Harold S. Kaufman, Max M. Kulvin, Richard S. Lewis, Warren Lindau, Archie McAllister, Jr., Robert A. McNaughton, Wayne B. Martin, E. A. Morgan, Jr., William Most, Harry C. Nelson, George M. Nipe, Howard B. Russman, James H. Smith, Parke G. Smith, Theodore R. Struhl, John E. Williams, Albert A. Wilson, G. Robert Yates.

MIAMI BEACH: Melvin S. Chuker, Sherman R. Kaplan, Morton B. Morgan, C. B. Wigderson. MIAMI SPRINGS: Albert W. McCorkle. NAPLES: Ethel H. Trygstad. ORLANDO: John E. Startzman. PLANT CITY: Frank Chambers, Jr. POMPANO BEACH: James A. Pickering. ST. PETERSBURG: Milton B. Cole, E. F. Dougherty, August E. Gehrke, Thos. J. Ready. SOUTH MIAMI: Ira K. Brandt. TAMPA: M. L. Naramore, Richard D. Owen, Curtis C. Rorebeck, Henry C. Sweany, Lester L. Zipser. TAVERNIER: Martin P. Mahrer. WEST PALM BEACH: Carl E. Andrews, Clarence L. Brumback, Theodore F. Gerson, Ronald M. Thompson.

ALABAMA — DOTHAN: John T. Ellis. ARKANSAS — FORREST CITY: Charles E. Crawley. DISTRICT OF COLUMBIA: Harle B. Grover. GEORGIA — ATLANTA: David H. Poer. AUGUSTA: Edgar R. Pund, Peter B. Wright. BRUNSWICK: John B. Avera. BYROMVILLE: Edgar B. Davis. SYLVANIA: Gerald B. Hogsette. ILLINOIS — CHICAGO: Steven O. Schwartz, Alfred L. Siegel, Philip Thorek. INDIANA — FORT WAYNE: Noah A. Rockey. HAMMOND: Antone C. Remich. JEFFERSONVILLE: John H. Baldwin. RICHMOND: Paul W. Blossom. KENTUCKY — LOUISVILLE: Warren W. Borsch. LOUISIANA — NEW ORLEANS: Maxwell E. Lapham. SHREVEPORT: Jos. S. Shavin. MARYLAND — BALTIMORE: Joseph V. Jeppi, William R. Stinger. HAGERSTOWN: Harry D. Bowman. MASSACHUSETTS — BOSTON: Douglas Davidson, Jack Mickley, William Jason Mixter. MICHIGAN — DEARBORN: William A. Bailey. DETROIT: Ira E. Falk, John L. Rosefield, Theodore I. Roth. EAST LANSING: Chas. R. McCorvie. PORT HURON: Edgar C. Sites. ST. CLAIR: Charlton A. MacPherson. MINNESOTA — DULUTH: Keith R. Fawcett. ST. PAUL: Harold Flanagan, Jerome A. Hilger.

NEW JERSEY — ENGLEWOOD: D. P. Catsman. MONTCLAIR: W. Alan Wright. SOUTH ORANGE: M. W. Amster. NEW YORK — BROOKLYN: William A. Weiss. BUFFALO: Clarence A. Straubinger. MONTICELLO: S. A. Kornblum. NEW YORK: Joseph E. J. King. NORTH CAROLINA — DURHAM: Lenox D. Baker. OHIO — CINCINNATI: Morris Hyman. CLEVELAND: Zolton L. Klein. COLUMBUS: Olan P. Burt. DAYTON: Robt. E. Boswell, E. R. Thomas. LANCASTER: Victor N. Kistler. MILFORD: Warren E. Thomas. YOUNGSTOWN: Alfred R. Cukerbaum. OKLAHOMA — LAWTON: Charles S. Graybill. PANAMA — COLON: Harry Eno. PENNSYLVANIA — CHAMBERSBURG: Jos. H. Engle. KITTANNING: Ivan N. Boyer. PHILADELPHIA: Harry E. Bacon. PITTSBURGH: John C. Hughes. READING: George Major. SOUTH CAROLINA — FLORENCE: Joseph G. Sylvester. TENNESSEE — CHATTANOOGA: Clarence Shaw. JOHNSON CITY: J. B. McKinnon. NASHVILLE: Ray O. Fessey. TEXAS — LUFKIN: James C. Klein. VIRGINIA — RICHMOND: John E. Collier, Austin I. Dodson, H. Hudnall Ware, Jr. WISCONSIN — ASHLAND: Clyde J. Smiles. GILLETT: Walter R. Berg. MADISON: John K. Shumate. MILWAUKEE: Ben L. Fabric, J. M. Jekel.

Other Guests

JACKSONVILLE: Mr. Ernest R. Gibson, Mr. Tom Jarvis, Mrs. Zoe Pack, Mr. Norman Ulbright. TAMPA: Mr. V. M. Newton.

ALABAMA — BIRMINGHAM: Mr. C. P. Loranz. ILLINOIS — CHICAGO: Mr. Alfred J. Jackson.

Annual Joint Report of Secretary-Treasurer Dr. Samuel M. Day Managing Director Dr. Stewart G. Thompson

In accordance with an action of the House of Delegates in 1951 this report was not read at a general session of the Annual Meeting in April 1952. The By-Laws were amended at that time to delete the provisions requiring that the report be read and to specify that it be published in The Journal only.

At the close of the fiscal year, March 20, 1952, the Association's membership totaled 2,285, which exceeded all previous records. A year ago, the total was 2,173. This represents a net membership increase of 112. The following members are not required to pay dues: life 103, honorary 83, excused 20, military 30; and secretaries of the county medical societies 35, making a total of 271. (There are 36 county medical society secretaries, but one is also a life member).

The six county medical societies ranking the highest in total membership are Dade, 589, Duval, 251, Pinellas 184, Hillsborough 169, Orange 152, Palm Beach 117.

Receipts for the fiscal year ending March 20 totaled $166,000.87, and disbursements $89,697.42. The difference between these two totals of $76,303.45 must not all be considered surplus. State dues are payable on a calendar year basis and the fiscal year totals are from annual meeting to annual meeting. If a large proportion of the annual dues are received before the annual meeting one year and not the following year the difference between income and disbursements will fluctuate, therefore, this difference cannot be used to compare one fiscal year with that of another.

As mentioned in last year's report, the increase in the membership dues was the difference between retrenchment and progress. The Association's activities during the past year have increased through careful planning and enthusiastic efforts of its capable officers and members.

Association's Headquarters

Your headquarters offices for more than twenty years have been located at 128 East Forsyth Street, Jacksonville. There are ten full time employees who are serving you faithfully and with loyalty. Aside from the Managing Director, Mrs. Zoe Pack, Chief Clerk, has the longest service record, totaling six years. Next is Mr. Ernest R. Gibson, Assistant Managing Director, with five years. Mr. Tom Jarvis has completed his first year as Assistant Supervisor of the Bureau of Public Relations.

Good equipment has been installed over the years, which adds greatly to the efficiency of handling a large volume of work. By means of an addressograph and an embosser, on which the address plates are made, changes of address are kept up to date daily. Each month the Journals are delivered to the office, where they are addressed before mailing. Letters, Briefs, etc., are also addressed on this machine. A postage meter which seals and stamps envelopes automatically has been a great time saver. An adding machine, typewriters, mimeographs, etc., are of good quality and serviced periodically toward better work and longer life.

It would be repetitious to include in the Annual Report a listing of the operations necessary to process an enormous amount of work. Annual Reports of past years which were published in your Journal contain details of expanding the equipment to care for the yearly increase of activities.

The increasing activities of the American Medical Association, State Medical Associations, and County Medical Societies add extra duties in your Association's office. To answer the inquiries through letters and questionnaires, and to keep abreast with the programs of these sister organizations, increase our load continually. Personal contacts in the office and correspondence in connection with doctors desiring places to locate in Florida, and with communities needing the services of a physician is a time-consuming operation that would amaze a person who had not followed the details personally. A large number of physicians have been assisted in finding suitable locations for their type of practice. The physicians who have visited the office have been briefed on pertinent points such as specialty, general practice, size of city, preferences, West Coast, East Coast, Central or North; whom to contact in a city, such as Society officials, bank officials, pharmacists, business men. Before locating, a physician naturally needs to know about payrolls, bank deposits, and sources of income of the citizens. This type of activity has increased since World War II and is largely caused by the abnormal movement of population.

A. M. A. Field Service Trip

As a result of communications with Mr. Leo Brown, AMA Director of Public Relations, we invited Mr. Lawrence W. Rember, Director of Field Service on Mr. Brown's staff, to schedule a field service trip to Florida. This trip was timed so that Mr. Rember was able to spend two days at the headquarters office in Jacksonville before proceeding to Tampa to observe the Association's exhibit at the State Fair.

While in the state he filled several speaking engagements and attended conferences which had been arranged by Association officials from Tampa and Jacksonville.

Mr. Rember visited the southeast portion of the state in the spring of 1950 and attended the Association's annual meeting. In scheduling this latest trip it was kept in mind that it would be beneficial for him to observe activities in other parts of the state.

The trip proved to be most productive. Following is a letter from Mr. Rember in which he makes a highly complimentary report of his second official visit to Florida:

"April 11, 1952

"Dear Dr. Thompson:

The field service trip which you invited me to make to Florida had everything in it a person would want out of a field trip.

I saw a great state association program in action, received a first-class post-graduate education in state medical association policies and programs, and was the recipient of unsurpassed hospitality. For all this I am greatly indebted to you.

I returned to Chicago with a wealth of valuable information as a result of my visits with your leaders in Jacksonville, and those in Tampa, St. Petersburg and Orlando. Nineteen memos — on state association budgets; health insurance plans; American Medical Education Foundation; blood bank program; field service; grievance committee; Negro doctors; medical schools; government public relations; suggested speakers; Medical Forum; Medical Committee For Better Government; literature holder; opinion poll; state dues; organizational pamphlets; A.M.A. Secretaries meeting; A.M.A. questionnaires; A.M.A. plaque; medical exhibit; member indoctrination; chiropractors, naturopaths, and osteopaths; legislative set-up; medical directory and press conferences; . . . — have gone to the general manager's office and key department heads here at the A.M.A.

The Florida expressions, ideas and suggestions outlined in these memos will be most useful, not only to the departments to which they have gone, but also to the PR Doctor and Exchange, our Loan packets, speeches, articles, conferring with other state and county medical societies, and in other ways.

A number of letters have also gone out to other societies and to people whom I met in Florida as follow-ups to my visit.

I feel that this is as fruitful a visit as I have ever had with any state, since I have been with the A.M.A.

You've got a great operation. I know that your contribution has been most substantial in making it so.

My thanks for everything. With every good wish.

Sincerely yours,

(sgd.) Lawrence W. Rember"

The Journal

The number of Journals printed during the past year totaled 30,746 as compared with 29,135 for the previous year, an increase of 1,611. The processing of the Journal is part of the duties of the office staff, under the direction of the editor and managing editor.

Medical Directory

One free copy of the 1952 Florida Medical Directory was mailed to each member of the Association. Additional copies may be purchased at $2.00 each. The demand for these medical directories is increasing from year to year. It is gratifying to find that the information contained in this publication is serving a statewide need.

Bureau of Public Relations

An 8-point overall public relations program compiled by the committee on Public Relations, published in July 1950, is the basic guide for activities of the Bureau of Public Relations. Point eight of this program, listed as general public relations, is subdivided into the internal, within the profession, and the external, or that which deals with the public.

In order to process this program and to strive to accomplish the stated objectives, the Bureau is anxious to serve Association committees when needed. During the past year, most of the requests for assistance have been received from the Committee on Public Relations. In addition its services are available to county society officials and their public relations committees. Contacts with the press, radio, and other reputable allied and lay organizations constitute a large share of the Bureau's activities.

In 1950 arrangements were made for 100 bookings in commercial theatres of Florida of "To Your Health," a ten minute sound picture depicting the inadequacies of government controlled medicine. To date 79 showings of the film have been made, 26 of these during the past fiscal year. Twenty-one bookings are yet to be made.

President David R. Murphey, Jr., and Dr. Eugene B. Maxwell, Chairman of the Committee on Public Relations, introduced two new public relations projects during the past year — an Association exhibit at the Florida State Fair in Tampa, and a Rural Educational Program. The Bureau has been assisting in both projects. Details and a picture of the Fair exhibit may be found in your May Journal. The Rural Educational Program is sponsored jointly by the Association and the Florida Agricultural Extension Service of both State Universities.

County medical societies are sponsoring a greater number of A.M.A. transcribed radio programs than at any previous time. These platters are available from the Bureau which also assists the local societies in making initial arrangements with the radio stations.

Health topics on items of medical interest have been supplied regularly throughout the year to weekly newspapers. Newspaper releases were prepared and distributed on medical district meetings, the annual convention, and on other occasions having special news value.

The Association again sponsored the Association of American Physicians and Surgeons essay contest. The Bureau supplied every junior and senior high school in the state with a packaged library kit. Cash awards of $100, $50, and $25, were made by the Association to the State winners; first, Miss Stella Lois Ward, St. Petersburg High School; second, Mr. William Ward Bellis, Central Catholic High School, Pensacola; and third, Miss Louise Baughan, Gainesville High School. Dr. Francis T. Holland of Tallahassee served as chairman of a committee of judges, assisted by Dr. Griffith T. Pugh, professor of English and Mr. Royal Mattice, associate professor of Economics, Florida State University. The three winning essays have been entered in the national contest sponsored by the A.A.P.S.

As in the past, field work throughout the state is one of the principal activities of the personnel of the Bureau staff.

Finances

The financial statement appearing at the end of this report is published in The Journal for the benefit of members who wish to study details. The books and records of the Association are open to the members, and we will be glad to answer inquiries of any nature upon request. The books have been audited by Goodrich & Varnedoe, Certified Public Accountants, and a certificate of the audit is incorporated in the statements which follow.

Respectfully submitted,
Samuel M. Day, *Secretary-Treasurer*
Stewart G. Thompson, *Managing Director*

April 16, 1952

Dr. Samuel M. Day
Secretary-Treasurer
Florida Medical Association
Jacksonville, Florida
Dear Sir:

In compliance with request of Mr. Stewart G. Thompson, Managing Director, Florida Medical Association, we have examined the books of account, vouchers and other records of the Association, maintained in his office, for the period March 21, 1951 to and including March 20, 1952, and submit herewith our report consisting of:

Exhibit "A" — Statement of Assets and Liabilities as at March 20, 1952
Exhibit "B" — Statement of Receipts and Disbursements for period March 21, 1951 to March 20, 1952
Exhibit "C" — Analysis of Changes in Retirement Trust Fund
Exhibit "D" — Statement of Receipts and Disbursements—Medical Postgraduate Course Committee

The recorded receipts were regularly deposited to the credit of the Association, and the disbursements appeared to be for proper purposes.

Bank balances were reconciled with books of account and we inspected war bonds of a maturity value of $40,325.00.

Due to inaccessibility of records of the various County Societies no attempt was made to verify remittances for dues, or the accounts receivable of the Association.

Yours very truly,
(Signed) Goodrich & Varnedoe
Certified Public Accountants

CHG/d

Exhibit "C"
Retirement Trust Fund
Analysis of Changes

March 21, 1951 Through March 20, 1952

BALANCE ON HAND— March 21, 1951			$15,829.65
ADDITIONS			
Transfers from General Fund		$3,600.00	
Income:			
Gross Interest on Bonds	$387.50		
Less: Accrued Interest Paid on Purchase	.34	387.16	
NET ADDITIONS			3,987.16
			$19,816.81
DEDUCTIONS			
Distributions to Dr. Stewart G. Thompson 10 Months @ $300.00			3,000.00
BALANCE ON HAND— March 20, 1952			$16,816.81

Exhibit "B"
Statement of Receipts and Disbursements
March 21, 1951 Through March 20, 1952

Balances —— March 21, 1951		
Florida National Bank—Checking A/c	$53,805.35	
Atlantic National Bank—Savings A/c	9.17	
Barnett National Bank—Savings A/c	1,902.22	$ 55,716.74
Receipts		
Back Dues	$22,975.00	
Current Dues	57,000.00	
Entrance Fees	1,910.00	81,885.00
Interest on Savings Accounts		19.06
Miscellaneous Income		565.69
Reprints—Non-Member		372.06
Advertising—Journal	15,388.72	
" —Directory	725.00	16,113.72
Journal Subscription & Sales		378.50
Directory Sales		427.10
Technical Exhibits		8,200.00
Convention Smoker		2,323.00
TOTAL RECEIPTS		110,284.13
TO BE ACCOUNTED FOR		$166,000.87
Disbursements		
Administrative:		
Postage and Express	$ 1,413.67	
Office Supplies	745.42	
Telephone and Telegraph	1,231.92	
Travel Expense—Mng. Dir. and Asst.	573.66	
Delegates to A.M.A. (3) Transportation	974.57	
Office Rent	2,400.00	
Bank Exchange	7.33	
Custody of Bonds	50.00	
Treasurer's Bond	225.00	
Comprehensive & Liability—Auto Insurance—Employees	29.65	
Employer's Liability Insurance	41.65	
Maintenance—Office Equipment	273.37	
Rental—Safety Deposit Box	12.50	
Blue Cross and Blue Shield (Assn. Employees)	194.40	
Federal Tax	562.13	
State Sales Tax	603.54	
Unemployment Compensation Fund	486.22	
Federal Excise Tax	54.03	
Furniture and Fixtures	1,111.32	
Books, Pamphlets, Etc.	263.63	
Payrolls	26,328.25	
Contractor Fees	1,589.81	
Retirement Trust Fund	3,600.00	
Journal Printing and Paper	15,096.70	
Dray	56.65	
Printing and Engraving	1,574.98	
Directory Printing, Etc.	1,650.10	
Convention Expense	3,555.90	
Reprints—Non-Member	275.89	
Miscellaneous Committee Expense	179.65	
Convention Smoker, Etc.	2,152.65	
Incidental	4.90	
TOTAL ADMINISTRATIVE		$67,319.49
Bureau of Public Relations:		
Postage and Express	$ 1,083.39	
Office Supplies	529.34	
Payrolls	10,458.26	
Contractor Fees	90.00	
Insurance—Blue Cross and Blue Shield	58.80	
Telephone and Telegraph	587.05	
Travel Expense—Supervisor	1,847.53	
Federal Tax	210.30	
State Sales Tax	54.48	
Unemployment Compensation Fund	249.63	
Federal Excise Tax	27.72	
Office Rent	1,272.00	
Furniture, Fixtures and Equipment	202.30	
Books, Pamphlets, Etc.	563.15	
Printing and Engraving	1,015.58	
Maintenance—Office Equipment	79.66	
Legislation, Public Policy	217.40	
State Education Campaign	3,714.34	
Incidental	5.00	
Chamber of Commerce Membership	100.00	
Press Association Membership	12.00	
TOTAL BUREAU OF PUBLIC RELATIONS		22,377.93
TOTAL DISBURSEMENTS		89,697.42
Balance—March 20, 1952		$ 76,303.45
Balance Comprised of:		
Florida National Bank—Checking A/c	$17,166.16	
Atlantic National Bank—Checking A/c	57,206.84	
Atlantic National Bank—Savings A/c	9.17	
Barnett National Bank—Savings A/c	1,921.28	$ 76,303.45

Exhibit "A"
Statement of Assets and Liabilities

March 20, 1952

Assets

Atlantic National Bank — Checking A/c	$ 57,206.84	
Florida National Bank — Checking A/c	17,166.16	
Atlantic National Bank — Savings A/c	9.17	
Barnett National Bank — Savings A/c	1,921.28	$ 76,303.45
Accounts Receivable:		
General Fund	$ 23,560.00	
Journal Fund	1,297.68	24,857.68
Inventory — Stationery		2,881.79
Retirement Trust Fund — Atlantic National Bank		16,816.81
Investments:		
Treasury and Savings Bonds		29,840.50
Depository:		
Barnett National Bank — Checking A/c		1,826.58
Furniture & Fixtures:		
General Fund	$7,654.71	
Less Depreciation Reserve	3,582.31	$4,072.40
Bureau of Public Relations Fund	$3,706.24	
Less Depreciation Reserve	853.91	2,852.33 6,924.73
TOTAL ASSETS		$159,451.54

Liabilities

Depository — Postgraduate Course Committee	$ 1,826.58	
Net Worth	157,624.96	
TOTAL LIABILITIES AND NET WORTH		$159,451.54

Exhibit "E"
Dues and Entrance Fees Collected March 21, 1951 Through March 20, 1952

Name of Society	Total Members	No. Paid Members	No. In Arrears	1952 Dues Collected	Back Dues Collected	Entrance Fees
Alachua	49	47	2	1,520.00	40.00	40.00
Bay	23	11	12	320.00	120.00	20.00
Brevard	22	17	5	520.00	40.00	20.00
Broward	83	67	16	2,360.00	600.00	60.00
Columbia	13	11	2	400.00	160.00	
Dade	589	379	210	13,240.00	8,815.00	440.00
DeSoto-Hardee-Highlands-Glades	27	23	4	720.00	80.00	20.00
Duval	251	148	103	4,600.00	3,440.00	250.00
Escambia	73	62	11	2,000.00	2,520.00	50.00
Franklin-Gulf	8	7	1	200.00	40.00	20.00
Hillsborough	169	134	35	4,600.00	1,600.00	130.00
Indian River	7	4	3	120.00		
Jackson-Calhoun	16	12	4	320.00	120.00	
Lake	26	21	5	760.00	200.00	30.00
Lee-Charlotte-Collier-Hendry	25	24	1	880.00	40.00	20.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	56	8	48		280.00	70.00
Madison	4	3	1	80.00		
Manatee	19	14	5	440.00	200.00	
Marion	28	15	13	400.00	200.00	10.00
Monroe	12	11	1	320.00	40.00	10.00
Nassau	10	9	1	240.00	40.00	10.00
Orange	152	122	30	4,400.00	1,040.00	110.00
Palm Beach	117	107	10	4,080.00	1,000.00	160.00
Pasco-Hernando-Citrus	16	15	1	440.00	80.00	20.00
Pinellas	184	174	10	5,960.00	520.00	140.00
Polk	91	77	14	2,520.00	560.00	100.00
Putnam	11	8	3	240.00	40.00	10.00
St. Johns	15	14	1	440.00		
St. Lucie-Okeechobee-Martin	15	7	8	240.00	160.00	
Sarasota	44	37	7	1,240.00	80.00	30.00
Seminole	16	16	0	560.00	80.00	30.00
Suwannee	9	5	4	120.00	40.00	10.00
Taylor	4	1	3		80.00	
Volusia	79	65	14	2,200.00	640.00	90.00
Walton-Okaloosa	16	15	1	400.00		10.00
Washington-Holmes	6	6	0	120.00	80.00	
Totals	2,285	1,696	589	57,000.00	22,975.00	1,910.00

Dues Not Payable			22,975.00 Back Dues Collected
Co. Sec. Secys.	35		
Life	103		79,975.00 Total Dues Collected
Excused	20		1,910.00 Entrance Fees Collected
Honorary	83		
Military	30		
		271	
Paying Dues		1,425	81,885.00 Dues and Entrance Fees

(Continued on page 903)

Report of Editor of The Journal
Dr. Shaler Richardson

Time passes quickly. For those of us who have been privileged to play some small part in medicine's progress it goes by with unbelievable rapidity.

Thirty-nine years ago the first issue of The Journal was ready for publication. Twenty-seven years ago the first number in which I had a part as editor was nearing completion. Since that time, the members have seen fit to return me to this office continuously except for the period when serving as president-elect and then president. This confidence has been most gratifying.

We are justly proud of the top ranking position we have attained and held among state medical journals through the years. We are fully aware that the contributions of the members have made this posisble. Without scientific articles there can be no Journal.

Membership in the Association has increased steadily since the close of World War II. Current figures show a monthly circulation of over 2,500; approximately 2,200 of these go to active members, the remainder being sent to individual subscribers, advertisers and exchanges.

In keeping with the times publishing costs are steadily increasing. Paper stock prices are at an all-time high with no leveling off apparent. In addition, the quality of paper used is quite difficult to obtain. This problem for The Journal has not yet reached serious proportion due to the efficiency and aggressiveness of the managing editor, and his long and honorable relations with reputable paper dealers. We have had notice from other state medical journals that they are discontinuing exchanges due to the shortage of paper.

Recently advertising rates were increased, but only in the small amount warranted by increase in circulation since the last rate change. The added revenue does not begin to compensate for advanced publishing costs.

During the past fiscal year, 53 scientific papers were published of which 44 were by members. Fifteen of the papers published, 10 by members and five by guest speakers, were read at the 1951 Hollywood meeting. In addition, the Committee on Publication accepted nine papers from non-members because these papers were deemed to contain timely scientific information which would benefit the members.

Abstracts provide members with information on scientific subjects. During the past year 57 abstracts of articles published by our members in other journals were published in The Journal. The staff is constantly scanning other journals for articles published by our members. However, some valuable papers may have been missed. Members can add value to this section by sending in reprints of their articles published in out-of-state medical journals.

We are especially proud of our editorial and commentary section. We believe it to be outstanding among the state medical journals. No small part of this is due to our ingenious and versatile assistant editor, Dr. Webster Merritt. Besides being a busy practitioner, Dr. Merritt rates among Florida's foremost historians. You will have noted in recent issues a series of editorials using an "anniversary" approach. Month by month outstanding events in medical history which, in bygone years, took place in the month of that particular issue, have been portrayed. Birth dates of famous medical men, dates of outstanding scientific discoveries and other leading events in medicine's march of progress have paraded across The Journal pages. These and other contributions of the assistant editor have been effectively illustrated.

An outstanding piece of historical research and writing appeared in the editorial section of a very recent issue of The Journal. In this Dr. Merritt gave a vivid portrayal of the misfortunes of the ill-fated Dr. Samuel A. Mudd who, unaware who his patient was, set the broken leg of John Wilkes Booth, who had received his injury in making his escape following the assassination of Abraham Lincoln. This editorial is accompanied by a double page illustration of Fort Jefferson, which was located on one of the Florida keys, where Dr. Mudd was imprisoned.

Members are always interested in news items and county society notes. These will continue to be an important part of The Journal, but they could be more valuable and informative with more contributions from the members. The staff looks for news, but many items of interest never come to its attention. The county societies which publish bulletins provide us with a constant source of information about their county activities and the activities of their members. A few of the societies have reporters whose duty is to see that news items and society notes reach The Journal regularly. Our primary source of information for the societies who have neither bulletin nor reporter is through a newspaper clipping service.

Other features of note are Your Blue Shield, State Board of Health and Books Received. For your convenience, The Journal carries a list of Association officers and committee members, a schedule of meetings of certain medical organizations and a tabulation of the county societies together with their presidents, secretaries, meeting dates and current membership. These should be almost invaluable to the members, particularly to Association officers, committeemen and county society officials. Yet the number of inquiries coming into the headquarters office for which the answers may be obtained from The Journal is surprising.

In addition to Dr. Merritt, I wish to express appreciation to the associate editors, Drs. Louis M. Orr, II, Franz H. Stewart, James R. Boulware, Jr., Herschel G. Cole, Wilson T. Sowder, Carlos P. Lamar, and Walter C. Payne. The assistance of Drs. Chas. J. Collins and James N. Patterson, the other members of the Committee on Publication have been invaluable. One or both of these members read and edited the scientific articles published in The Journal before they were finally referred to me. This takes time and effort which should merit the special appreciation of the membership.

The smooth functioning of the abstract section of The Journal can be attributed to the abstract chairman, Dr. Kenneth A. Morris, and his able helper, Dr. Walter C. Jones.

A journal is as good as its managing editor. I want to express sincere appreciation to Dr. Stewart Thompson for many years of good and faithful service. Mr. Ernest Gibson, journal technician, has also rendered invaluable assistance. Special mention goes to Mrs. Edith B. Hill, manuscript editor, who carefully edits all scientific papers before they are sent to the printer. She also assists on editorials and commentaries.

The Journal belongs to the members. The editor and his staff can only utilize that which the members contribute. Comments and criticisms are most welcome. Only if the members make known their desires will The Journal staff be able to give them the kind of publication they would like to have.

Respectfully submitted,
Shaler Richardson, *Editor*

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Robert Boyd McIver, M.D., President

A South Carolinian of distinguished lineage, Dr. Robert Boyd McIver was born in Spartanburg, S. C., on April 19, 1892. He was the son of John Kolb McIver III of Society Hill and the former Mary Louise Boyd of Darlington, S. C. After graduation from the Boys Preparatory School in Moultrie, Ga., in 1908, he entered Wofford College in his native city, where he received the Bachelor of Arts degree four years later. In 1916, he was awarded the degree of Doctor of Medicine by the Jefferson Medical College of Philadelphia. Among his undergraduate honors were the highest average in the senior class, a gold medal in Surgery, a gold medal in Obstetrics, and membership in Alpha Omega Alpha scholastic fraternity.

On completion of his residency at the Pennsylvania Hospital in Philadelphia in 1918, Dr. McIver entered the Medical Corps of the United States Army. Before going overseas, he served as ward surgeon at Camp Jackson, S. C.; then, in France, he first was assigned to duty as surgeon with a mobile operating team on detached duty from Base Hospital 60 and later as Assistant Chief of the Surgical Service at the hospital in Tours. He was discharged from military service in 1919 with the rank of captain.

In 1920, Dr. McIver entered the private practice of medicine in Jacksonville. After five years' graduate training in genitourinary and general surgery as Associate to the Chief of Surgery in Duval County and St. Vincent's hospitals, in 1925 he limited his practice formally to genitourinary and general surgery, and ten years later to genitourinary surgery only. He is now Chief of the Department of Urology and a past president of the staff of St. Vincent's Hospital and of the Duval Medical Center; in both of these institutions he established an approved residency in urology. He serves as Consultant in Urology at the Flagler and East Coast hospitals in St. Augustine and the Veterans Administration Hospital in Lake City.

A past president (1932) of the Duval County Medical Society, Dr. McIver was elected Secretary-Treasurer of the Florida Medical Association in 1944. He served with distinction in this office until he became President-Elect in 1951. Since 1920, he has held membership in these two organizations, and also in the American Medical Association and the Southern Medical Association. His affiliation with the Southeastern Section of the American Urological Association dates from 1936, and in 1948 he served as president of this organization. In 1938 he became a member of the American Urological Association, and two years later a diplomate of the American Board of Urology. Since 1924 he has been a fellow of the American College of Surgeons.

This eminent medical leader long has enjoyed a national reputation as a speaker and lecturer. He is constantly in demand by medical, surgical and

urologic societies in many states. As the lecturer on urology, he has served as a member of the faculty of postgraduate short courses in such Southern cities as Charleston, S. C., Dallas and Houston, Texas, and Louisville, Ky. He has delivered the Oration on Surgery at the Academy of Surgery in Nashville, Tenn., the Academy of Surgery in San Diego, Calif., and the Academy of Surgery in Hollywood, Calif. As guest speaker, he has addressed the Mid Atlantic Section of the American Urological Association, the Medical Society of the State of North Carolina, and the Medical Association of the State of Alabama. In addition, he has filled many speaking engagements, especially before urologic societies, throughout the nation.

Through the years, Dr. McIver has rendered outstanding service to his community and state. For a decade he has been a member of the Florida State Board of Health. He was a founder and since 1942 has been president of the Jacksonville Blood Bank. During World War II, he served as Chief of the Medical Department, Civilian Defense, for Jacksonville and Duval County. At present, he is general chairman of St. Vincent's Hospital Expansion Fund.

In 1929, Dr. McIver and Miss Ida Arwyn Holmes of Jacksonville were united in marriage. They have two children, John Kolb McIver V, now a student at Trinity College in Hartford, Conn., and Laurina Holmes McIver, who is attending Pine Manor Junior College in Wellesley, Mass.

An Episcopalian, Dr. McIver is a communicant of St. John's Episcopal Cathedral in Jacksonville and active in Christ Church at Ponte Vedra Beach, where he resides a part of each year. He enjoys a diversity of interests. His recreational activities center in saddle horses, boxer dogs and deep sea fishing. Locally, he is a former Rotarian and a member of the Seminole Club, the Timuquana Country Club, the Florida Yacht Club and Ye Mystic Revelers.

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Seventy-Eighth Annual Convention

Registration figures show that attendance at the seventy-eighth annual convention in Hollywood April 27-30 was at an all time high. The total registration was 1,621. Included in these figures are 964 physicians, 7 other guests, 444 members and guests of the Woman's Auxiliary, and 206 representatives of exhibiting firms. There were 23 other states and Panama represented. The complete registration list is published at the end of the proceedings on page 880.

Just prior to the adjournment of the Second House of Delegates, Dr. Robert B. McIver of Jacksonville, who has served the past year as president-elect, was installed as president. Other officers elected to serve with Dr. McIver for the coming year are Drs. Frederick K. Herpel of West Palm Beach, president-elect; Francis H. Langley of St. Petersburg, first vice president; Erasmus B. Hardee of Vero Beach, second vice president; H. Quillian Jones of Fort Myers, third vice president. Re-elected to office were Drs. Samuel M. Day, secretary-treasurer, and Shaler Richardson, editor of The Journal, both of Jacksonville.

Dr. McIver's first official act was presenting to the retiring president, Dr. Murphey, the past president's button and certificate of honor. Dr. McIver, also, in a colorful ceremony presented each living past president a hardwood gavel encircled by a solid silver band on which was engraved the past president's name and the year of his administration.

Four Scientific Assemblies, two General Sessions and two meetings of the House of Delegates were crowded into two and one-half days, Monday morning until Wednesday noon. In accordance with an action of the House of Delegates last year, Dr. David R. Murphey, Jr., gave his presidential address at the first meeting of the House of Delegates on Tuesday morning. Immediately following adjournment of the first House of Delegates the guest speaker, Dr. William Jason Mixter of Boston, presented a paper during the Second General Assembly. Two innovations this year, which proved popular with the members, were scientific motion pictures on Tuesday morning in the theatre and the giving over of the entire third scientific assembly to a symposium on hypersplenism.

The three reference committees appointed by the president gave careful consideration to committee reports and resolutions presented at the first meeting of the House of Delegates. Their study

and recommendations on these measures aided greatly in the dispatching of business at the second meeting of the House.

Again the great lounge of the hotel was filled to capacity with many fine technical and scientific exhibits. The officers and members of the Association are deeply appreciative for the contributions and wealth of information provided by these exhibits.

Continuing a policy inaugurated last year, a double booth was reserved for the exclusive use of the county medical societies. In this booth, three interesting displays featured the Dade County Bulletin, the Picomesco Mail Bag of the Pinellas County Medical Society and the Palm Beach County Medical Society Directory. The Mail Bag featured a special edition which carried information on the highly successful public forum conducted by the society during the past year. Other county medical societies are urged to use this booth at future conventions.

Seventeen specialty groups assembled for meetings on Sunday. Since many of these were meeting simultaneously, it taxed the facilities of the Hollywood Beach Hotel to provide assembly rooms.

The time and effort contributed by the convention committees on smoker, golf, anglers, Woman's Auxiliary Advisory, and the Association dinner, contributed greatly to the success of the 1952 convention.

Over 1,000 members and guests enjoyed a gala water show at the Hollywood Beach Hotel pool during the annual smoker on Monday evening. Refreshments and dancing followed the show. The huge hotel dining rooms were filled to near capacity on Tuesday evening at the Association dinner. Continuous large attendance at these functions necessitate great care in the selection of convention sites in order that adequate facilities may be available.

The Hollywood Beach Hotel has again been selected as headquarters for the 1953 convention. The dates for this meeting have been set by the Board of Governors for April 26-29.

Convention Golf Tournament

The Annual Golf Tournament held in connection with the Association Meeting, was quite successful on the basis of the number of entries as well as interest shown by members from all parts of the State. Over 72 players turned in scores. The winning scores were determined on the basis of 18 holes played at the Hollywood Beach Hotel Golf Course.

The prizes were awarded prior to the Annual Dinner and the names of the winners were announced at the Dinner Tuesday evening.

The trophies were displayed during the three days of play in one of the shop windows along the arcade of the hotel. Included in the list of prizes this year was the beautiful Duval County Society trophy which is to be awarded annually to the low gross winner. This year it was won by Dr. John D. McKey of Orlando, who shot a 71, which is an excellent score for the Beach Golf Course.

The Orlando Cup, which has been in play for a number of years, was won by Dr. Willard F. Ande of West Palm Beach. This cup is awarded on a handicap basis.

Dr. E. Hampton Bryson of Coral Gables won the Keleket Sup, which is awarded annually to a member of the Radiological group.

Other winners of prizes included: Dr. Thomas F. McDaniel, Sanford; Dr. Charles R. Burbacher, Coral Gables; Dr. Melvin Newman, Jacksonville; Dr. Reuben L. McDaniel, Jacksonville; Dr. George H. Putnam, Gainesville; Dr. Raymond M. Price, Ft. Lauderdale; and Dr. Walter F. Davey, Stuart.

Convention Anglers

Prizes to anglers were announced Tuesday evening at the Association dinner by Dr. Edgar J. Stephens of West Palm Beach, chairman. First prize for the longest and heaviest fish was won by Dr. Thomas E. McKell of Tampa, with a 7 foot 8 inch sailfish. Dr. William S. Mitchell of Orlando, who fished all day with no results, was awarded the prize for the smallest fish.

Vast Expansion of Medical Colleges

Recently The New York Times reported on a survey it had made of the nation's 73 four year and seven two year medical colleges, and 48 state commissioners of education.[1] The survey showed that the greatest expansion program in the history of medical education, estimated to cost a quarter of a billion dollars, is now in progress in this country.

Within the next few years the medical schools plan to spend $50,000,000 for laboratories, $30,000,000 for classrooms and $20,000,000 for dormitories. Another $100,000,000 is to be directed to research and special projects. In addition, the immediate cost of establishing new medical institutions is expected to exceed $50,000,000.

The Times notes that at least 10 states have taken steps to build new medical schools or expand their two year basic science schools into four year institutions. Among them, Florida, in the South, and New Jersey, Connecticut, Rhode Island and Massachusetts, in the East, have appointed commissions or set machinery in motion to found medical colleges. Also in the South, the University of Mississippi is proceeding rapidly with its plan to make a regular four year medical school out of its two year basic science institution.

These new medical projects are all planned under public auspices. The only new medical college under private sponsorship is the $25,000,000 medical center being established in New York City under the guidance of Yeshiva University, which is to be affiliated with the city's $36,500,000 hospital project in the Bronx.

Approximately one third of the nation's medical schools reported that they were unable to get sufficient funds to meet their operating budgets, and almost half reported difficulty in getting a sufficient number of qualified faculty members. Many were engaged in campaigns to "keep their heads above water."

Many institutions are increasing their enrolment to meet demands for more physicians. In the current academic year — 1951-1952 — the largest freshman classes in recent history, totaling 7,381 students, were admitted to medical colleges. The total enrolment is now slightly over 26,000, compared with 23,000 five years ago. There were, however, some 20,000 persons seeking admission to American medical schools for the current college year, many then turning to foreign institutions. The total number of applications exceeded 70,000, or an average of 3.5 a student, since many applied to more than one school. One fourth of the schools now exclude all students not residing in the state, and half give preference to residents.

More than three fourths of the deans of the medical schools advocated further expansion of medical facilities. Dean R. Hugh Wood of Emory University School of Medicine warned that classes of more than 100 may weaken the present high medical standards. He favored additional schools rather than greatly increasing the enrolment of existing schools. Dr. Wood observed: "One of the present threats to the quality of medical education stems from the fact that members of state legislatures do not understand this point. There have been several instances in the last few years in which the state government has ordered the medical school of the state university to increase its enrollment without providing additional facilities and budget."

That the present enrolment can be increased without lowering the quality is the opinion of many medical authorities, but it is contingent upon obtaining sufficient funds to add to the physical plant and increase the faculty. That a record expansion program is under way is attested by the fact that almost half of the colleges are now in the midst of fund-raising campaigns. They are seeking some $200,000,000 from public sources and private individuals or from foundations, and more than four fifths of them plan to use the money for expansion of their physical facilities.

It is gratifying indeed that everyone reached by The Times' survey urged that the high standards in medical education be safeguarded.

1. Fine, B.: Medical Colleges in Vast Expansion, The New York Times, Sunday, March 2, 1952.

Southwest Florida Tuberculosis Hospital

The new Southwest Florida Tuberculosis Hospital, located in Tampa, was dedicated late in March. Now nearing completion at a cost of approximately $4,500,000, including fixtures and equipment, this ultramodern institution is almost ready for occupancy. It differs from similar hospitals at Orlando, Marianna and Lantana, and the one nearing completion at Tallahassee, in that it will have a Central Control Laboratory.

Dr. Henry C. Sweany, chief medical director of the State Tuberculosis Board, described the laboratory as the heart of the treatment program, "since it is the laboratory where the control work is done of functions pertaining to the bacteriology, cytology and body chemistry, as well as the bacteriology of the disease." Accordingly, the Central Control Unit was selected because of its many advantages both from the economic standpoint and the standpoint of quality of service. It is designed to accommodate not only the various phases of laboratory work for the Tampa institution, but also any special problems that may arise in the several other hospitals, whose laboratories will handle only the routine problems.

Among the numerous departments in this laboratory unit are a complete laboratory for the bac-

teriology of tuberculosis; a laboratory "kitchen" for sterilization of septic material; a complete biochemical laboratory; a special physiologic laboratory for the study particularly of lung and cardiac function, in conjunction with or preparation for lung surgery; and a unit for the central buying and control of drugs and chemicals.

A special bacteriology laboratory is provided for the study of special micro-organisms, particularly yeasts and molds, which frequently cause confusion in the diagnosis of tuberculosis. Here the study of any form of plant or animal parasites may be made. These facilities will be available to the State Board of Health, which has similar needs for this type of special laboratory service.

A medical library is another special service provided. It is proposed to have the medical librarian prepare bibliographies for all physicians and workers throughout the hospital system. An innovation will be a film library, whereby all the important periodicals will be recorded on films and made available for use by anyone throughout the hospital system.

The Doctor Who Delivered a Town

Some 600 members of the cattle and fishing community down on the southwest shore of Lake Okeechobee gathered recently to honor a distinguished fellow citizen for long service in their midst. They thronged the city park in Moore Haven on April 20 to pay tribute to the town's only doctor.

It was in 1919 that Dr. Duncan M. Draughn arrived in Moore Haven from Mississippi to begin the practice of medicine. More than three decades later, he was privileged to lead a parade of his "babies" down the main street as a feature of the celebration in his honor. They ranged in age from babes-in-arms to some who had passed the 30 year milestone.

Here was "the doctor who delivered a town" — and more, for it so happens that the 1,500 babies he assisted into the world number more than twice the town's population of 635 and also more than half the 2,200 inhabitants of the county.

Reminiscing on his career as a country doctor deep in the heart of Florida, Dr. Draughn, from the vantage point of his 65 years, recalled the days when he had to depend upon rowboats and mules to reach his patients. With no modern drugs to combat infection, he used to go armed with "a huge bag of supplies like basins and linen" in order to have everything he needed. Now he sends expectant mothers to the new hospital in Clewiston, 16 miles away.

As he eyed appreciatively the television set presented to him by fellow townsmen and admirers and joined them in partaking of the bounteous repast they had provided for the occasion, he commented, "A home really isn't the place for childbirth. Babies should be delivered where modern facilities are available."

BIRTHS AND DEATHS

Births

Dr. and Mrs. James E. Blades of Nokomis announce the birth of a daughter, Dolores Alice, on April 5, 1952.

Dr. and Mrs. Walter B. Clement of Punta Gorda announce the birth of a daughter, Theresa Lynn, on April 7, 1952.

Dr. and Mrs. James M. San of Tampa announce the birth of a daughter, Harriet Loretta, on April 9, 1952.

Dr. and Mrs. Linus W. Hewit of Tampa announce the birth of a daughter, Rebecca Jane, on April 15, 1952.

Deaths — Members

Hughes, Robert L., Bartow ..... April 10, 1952
Bradley, James A., St. Petersburg ..... April 16, 1952
Parnell, Henry E., Perrine ..... April 20, 1952

Deaths — Other Doctors

Hutchings, Ernest H., Sparta, Ga. ..... Dec. 2, 1951
Stull, H. Tuttle, Chevy Chase, Md. ..... Dec. 18, 1951
Edmundson, Frank B., Clearwater ..... March 27, 1952
Lowry, Casper F., Tampa ..... March 30, 1952
Flipper, Emory H. (Col.), Jacksonville ..... Recently

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Asters, Constantine A., Orlando
Austin, Grover W., St. Petersburg
Beidelman, Barkley, Pensacola
Campbell, Elmer B., Jr., St. Petersburg
Carr, Douglas W., Clearwater
Certo, Salvatore I. A., Miami
Chesney, John G., Miami
Gardner, Melvyn J., Miami Beach
Hicks, Wright G., Apopka
Jenkins, Valentine E., Miami Beach
Lauer, John A., Jr., Tallahassee
Kilmark, Robert M., St. Petersburg
Manni, Lawrence C., Marianna
Mein, Robert M., Jacksonville
Neustein, Samuel, Miami
O'Neill, John B., St. Petersburg
Robertson, James F., New Smyrna Beach
Russell, Robert M., Dunnellon
Wood, George O., St. Petersburg
Yanowitz, Meyer, Miami

STATE NEWS ITEMS

The second biannual meeting of St. Luke's Hospital Intern and Resident Alumni Association has been set for 6:30 p.m., Sunday, June 22, at the George Washington Hotel in Jacksonville. Dinner will be served. Dr. Nathan Weil, Jr., of Jacksonville has called attention to the fact that Sunday, June 22, is the day following the Seminar on Diagnoses scheduled for June 19-21, and the day before the Twentieth Annual Short Course of the Florida Medical Association, which is scheduled to begin Monday, June 23.

Dr. Robert H. Hutchinson of Tallahassee, president of the Alumni Association, urges all physicians who have served as interns or residents at St. Luke's to include the Sunday evening meeting in their plans for attending the Seminar or the Graduate Short Course.

Dr. Maurice I. Edelman of Miami announces the opening of an additional office in Miami Beach at 605 Lincoln Road, for the practice of Ear, Nose, Throat, Bronchoscopy and Plastic Surgery.

Dr. Bernard J. McCloskey of Jacksonville has returned to his practice after attending the meeting of the American College of Allergists in Pittsburgh.

Dr. Robert B. McIver of Jacksonville, president of the Association, was guest speaker at the annual meeting of the Medical Association of the State of Alabama, April 17, in Montgomery. He presented a paper on "Plastic Surgery of the Renal Pelvis."

Dr. Bruce R. Tinkler of Lake Wales announces the opening of his new office at 24 Orange Avenue.

Dr. Nathan S. Rubin of Pensacola was one of several speakers who talked on general and specific health problems of children at a recent P.-T.A. meeting at the N. B. Cook School in that city. His subject was "Care of the Eyes."

Dr. Sidney Stillman of Jacksonville spoke on the problems of cancer in America at a recent dinner meeting of the South Jacksonville Kiwanis Club. He also showed a film on cancer entitled, "The Traitor Within."

Dr. Glenn O. Summerlin of Gainesville spoke at a recent meeting of the Rotary Club of that city. He urged a good response to the cancer fund drive.

Dr. Theodore Norley of West Palm Beach spoke on "Hip Dysplasia" and illustrated his talk with slides at a recent meeting of the Parents Group of the Palm Beach County Crippled Children's Society at the clinic.

Dr. Paul H. Jahn of Winter Haven spoke at a meeting of the Winter Haven Shrine Club in April. He told the group that they were aiding in keeping up the high standards of the medical profession which plays a major part in bringing capable young physicians to a town.

Dr. Frank G. Slaughter of Jacksonville has used the drama of surgery as the theme of his latest book, "East Side General." The emphasis of this new book is chiefly on medicine, and the background is that of a great New York Hospital.

Dr. Mozart A. Lischkoff of Pensacola talked on "The Headache Problem and the Otolaryngologist," at the second annual meeting of the Eye, Ear, Nose and Throat Alumni Association in New Orleans in April. Dr. Lischkoff is president of the Association.

Dr. Corren P. Youmans of Miami who retired recently as commander of the 202nd Medical Battalion of the Florida National Guard was awarded a plaque by members of the battalion in recognition of his long period of service. He was retired in the rank of Brigadier General.

Dr. Youmans has been succeeded by Dr. Lorenzo L. Parks of Jacksonville, who holds the rank of Colonel.

The Southern Pediatric Seminar will hold its thirty-first annual session July 14-26, 1952, in Saluda, N. C. Following the Seminar, July 28-August 2, a week of study will be devoted to obstetrical and gynecological problems.

This Seminar is primarily for the benefit of general practitioners. Outstanding teachers and clinicians from various Southern states comprise the faculty. Leaders of the Seminar are encouraging physicians to bring their wives and families. The course is fully accredited for postgraduate requirements in the Academy of General Practice. For further information, write: Dr. D. L. Smith, Registrar, 187 Oakland Avenue, Spartanburg, S. C.

Dr. Hawley H. Seiler of Tampa spoke on "Surgery in the Treatment of Heart Disease" at a recent meeting of the Tampa Civitan Club.

Dr. Henry E. Branca of Fort Pierce has returned to his practice after attending a postgraduate course in endaural surgery at Lemperts Endaural Institute in New York City.

Members of the Florida Medical Association who attended the American Academy of General Practice annual scientific meeting in Atlantic City in March were Drs. William G. Mason, Clearwater; Thowald D. Sandberg, Coral Gables; Richard A. Mills, Fort Lauderdale; Walter W. Sackett, Jr., Miami; Henry L. Harrell, Ocala; Charles D. Bailey, Leroy M. Sutter, Benjamin M. Cole, and L. Paul Foster, Orlando; William G. Meriwether, Plant City; Karl R. Rolls, Sarasota; Frank T. Linz and Paul J. McCloskey, Tampa; and Walter B. Johnston, Winter Park.

COMPONENT SOCIETY NOTES

Bay

At the April meeting of the Bay County Medical Society, Dr. Harold E. Wager presented a scientific movie on the diagnosis and treatment of glaucoma. Following the film, there was a general discussion on the subject.

Broward

The Broward County Medical Society with the local P.-T.A., the Broward County Dental Association and the county health department is sponsoring annual physical examinations for children who will enter the first grade in September. Remedial defects will be reported to parents, so that treatment may be given during the summer. Treatment is to be provided for children of the parents unable to meet the expense.

Columbia

At the annual meeting in Hollywood, Dr. Thomas H. Bates of Lake City was elected an Alternate Delegate to the A. M. A. House of Delegates to serve through 1955.

Dade

At the regular meeting of the Dade County Medical Association in April, candidates for the Florida Legislature appeared on a program. Public health problems, the continued future of the University of Miami School of Medicine and other topics of interest were discussed.

At the recent meeting in Hollywood, Dr. Reuben B. Chrisman, Jr., of Miami was elected a Delegate from the Florida Medical Association to the A. M. A. House of Delegates for a two year term starting Jan. 1, 1953.

Duval

The Duval County Medical Society is sponsoring a radio program over WJAX, Jacksonville. Programs will be composed of A. M. A. transcriptions selected by the Society's Committee on Public Relations.

Members of the Duval County Medical Society visited schools in Jacksonville in April to explain the urgency of a successful completion of the "Lights On Cancer Crusade," since many homes were not called on during the campaign. Taking part were Drs. A. Judson Graves, Frederick H. Bowen, Nathan Weil, Jr., Richard G. Skinner, Jr., Milton C. Maloney, Eugene M. Frame, C. Burling Roesch, Samuel S. Lombardo and James V. Freeman.

At the May meeting, 46 members of the Duval County Medical Society gave blood in a move to stimulate public interest in the Armed Services Blood Program. Collection of blood was directed by Dr. Robert B. McIver, medical director of the Duval County Blood Bank, Dr. James C. Lanier, Jr., and Mrs. Dorothy Smith, supervisor of the Duval County Blood Bank. Speakers included

(Continued on page 898)

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(Continued from page 897)

Dr. George B. Dowling, a retired Admiral, of Atlanta, regional director of the southeastern area of the American Red Cross national blood procurement program; Capt. R. W. Murray, Medical Corps, United States Navy, a representative of the President's Advisory Council for the blood program and member of the Armed Services' Blood Distribution Committee; Mr. Homer Kidd, field representative for the American Red Cross; Mr. Norris Herrington, director of defense plasma production for the Sharp and Dohme Pharmaceutical Laboratories; and Dr. James J. Griffiths of Miami, associate director of the Dade County Blood Bank.

At the Association's annual convention in Hollywood in April, Dr. Robert B. McIver of Jacksonville was installed as president. Re-elected to office were Dr. Samuel M. Day, secretary-treasurer, and Dr. Shaler Richardson, editor of The Journal, both of Jacksonville.

Escambia

Dr. Herbert L. Bryans of Pensacola was elected a Delegate to the A. M. A. House of Delegates at th F. M. A.'s recent meeting in Hollywood. He will serve through 1955.

Hillsborough

At the regular April meeting of the Hillsborough County Medical Association, Dr. Charles C. Lund, Boston surgeon and president of the American Cancer Society, was the guest speaker. Dr. Lund is associate professor of clinical surgery at Harvard Medical School and has devoted much of his long and distinguished career to the control of cancer.

Indian River

Dr. Erasmus B. Hardee of Vero Beach was elected second vice president of the Florida Medical Association at the recent annual meeting of the Association in Hollywood.

Lake

The regular meeting of the Lake County Medical Society was held at the Floridan Country Club on April 2.

Lee-Charlotte-Collier-Hendry

At the recent Hollywood meeting, Dr. H. Quillian Jones of Fort Myers was elected third vice president of the Florida Medical Association.

Marion

At the regular monthly meeting of the Marion County Medical Society on April 15, the guest speaker was Dr. A. H. Letton, assistant to Surgeon T. C. Davison of Atlanta, who spoke on "The Treatment of Pre- and Post-operative Complications." The talk was illustrated with lantern slides. There were 31 members, wives and guests present.

Orange

Dr. Frank D. Gray of Orlando was re-elected an Alternate Delegate to the A. M. A. House of Delegates at the annual meeting of the Florida Medical Association in April. He will serve a two year term beginning Jan. 1, 1953.

At the regular monthly meeting of the Orange County Medical Society on April 16, representatives from two insurance companies presented their plans for group health and accident insurance. Following this, a scientific film entitled, "Principles of Penicillin Therapy," was shown.

Palm Beach

The annual Doctor's Day Dinner for members of the Palm Beach County Medical Society was held on April 12 at Whitehall Hotel, Palm Beach.

Dr. Frederick K. Herpel of West Palm Beach was elected president-elect of the Florida Medical Association at the recent meeting in Hollywood.

Pinellas

At the regular meeting of the Pinellas County Medical Society on May 5, Dr. Walter H. Winchester presented an educational movie on "Injuries of the Peripheral Nerves."

Dr. Francis H. Langley of St. Petersburg was elected first vice president of the Florida Medical Association at the April meeting in Hollywood.

St. Johns

At the regular meeting of the St. Johns County Medical Society on April 15, Dr. William A. Walter, Jacksonville, Director, Division of Venereal Disease, Florida State Board of Health, gave a talk on laboratory technic.

All members of the St. Johns County Medical Society have paid their state dues for 1952.

Sarasota

Members of the Sarasota County Medical Society have paid 100 per cent of their state dues.

Suwannee

All members of the Suwannee County Medical Society have paid their state dues for 1952.

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AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Oraz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McOonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerlon, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossell, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past two years, more than 200 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 883 patients on whom reports were available.

In all but 9.7 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

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President's Message

I deem it a great honor to have been elected to serve as your president for the ensuing year. My knees have been shaking ever since the election in Hollywood just a year ago. I feel all my inadequacies, but find that in discussing these qualms with my predecessors, this reaction is a perfectly normal one — they all felt the same way.

I consider it not only an honor to serve as your president but a privilege to be a doctor's wife. I realize that this privilege carries a tremendous responsibility. The Auxiliary is the only organization to which we belong that devotes its energies to promoting the aims of the medical profession. We should take an active part in worthwhile civic projects in our communities, but remember to keep our Auxiliary at the top of that list. Someone else can occasionally take our places in P.-T.A. or Literary Clubs, but only we can do Auxiliary work. We can be a powerful force for good public relations in our communities as individuals and as members of an Auxiliary. We can encourage our husbands to attend their county and state medical meetings, thereby strengthening these organizations.

These are troubled times for our nation. The medical profession faces political problems at all levels — National, State and Local. It behooves us to help our doctor husbands in any way we can so that their tireless efforts can be seen in the proper light by our communities. Every eye is upon our every deed. Every ear listens to hear



Mrs. Herschel G. Cole
President, Woman's Auxiliary

words which can be interpreted to their liking. How better can we help than by endeavoring to carry out the aims of our Auxiliary in quiet harmony?

It is a cause near to all our hearts. I am honored to serve at this time when we can all dedicate ourselves anew to furthering the best interests of the profession to which our husbands have so unselfishly dedicated their lives.

Mrs. Herschel G. Cole, President



Annual Report of the President Woman's Auxiliary to the Florida Medical Association

Mrs. C. Robert DeArmas
Daytona Beach

It is with a sense of humility and a deep feeling of gratitude to the executive board and auxiliary members of the Woman's Auxiliary to the Florida Medical Association that I present my report for the year 1951-1952. For at no time during the year is it more obvious how little could have been accomplished under my leadership without the cooperative and intelligent participation of the active auxiliary members. This is obvious because in this report I speak not of what I would like to achieve, but of what has been achieved; and to determine that I must turn to the reports of the officers, committee chairmen and county presidents who came from all parts of the state in Florida in October to attend the Executive Board meeting where we planned the itinerary for the year.

Because of the excellent leadership in each county as well as the personal initiative of the members of my board we exceeded our expectations. So with a backward glance, we can count the mile posts and gauge the distance traveled this year.

Mrs. Herschel Cole, president-elect, accomplished the production of a Florida Handbook. The first of its kind in the twenty-five years of Auxiliary activity, this book will serve as a guide to the counties. It clarifies the relationship among county, state and national auxiliaries and explains the function of each, making it possible to follow the correct path in every direction.

Through the efforts of our organization chairman, Mrs. J. C. Davis, and her committee, we increased in membership from 936 to 1,169. We gained three new counties raising the number of organized areas from 19 to 22 with one member-at-large. Another county organized too late to be counted this year.

Through the able and diligent efforts of Mrs. R. F. Stover and her county chairmen, *Today's Health* has soared in popularity throughout all counties. The entire membership of some auxiliaries subscribing with their dues and honorable mention was achieved by Escambia County in the national contest.

The public relations leadership of Mrs. James Anderson and the county P. R. activity accomplished a desirable rapport and solid working relationship with the Florida Medical Association by cooperation in every area in the furthering of the Association's aims by manning booths at fairs; getting out educational literature; stimulating interest in registering and voting as well as studying the candidates and the issues currently before the public; encouraging and providing opportunities for self-education; sponsoring radio programs prepared by the A. M. A. extension bureau; aiding in the rural health program as well as by providing individual volunteers in all civic efforts. The doctor's wife of Florida has proved through good public relations that she not only can keep a watchful eye on legislation to protect the American way of life, but also that she is a contributor to it.

Mrs. Anderson by attending all five Medical District Meetings made our "Work-shop" dream a reality. With vigor and clarity she provided information and guidance in Auxiliary affairs.

Mrs. David Goddard, program chairman, compiled a complete program list in colorful booklet form enabling all counties a choice of program suggested by National. Her county chairmen showed discernment in the selection of the ones which were applicable to the local area.

Successful efforts were made by Mrs. H. Milton Rogers and her committee chairmen through the counties to stimulate interest in the National Bulletin, which resulted in an increase in subscriptions.

Mrs. Frank Slaughter, historian, compiled the Mid-Century History of Florida Auxiliaries which involved the tremendous job of gathering the records of twenty-five years and putting the information in readable form. This history has been incorporated in the Florida Handbook and a copy sent to the national historian. This epochal work is another demonstration of the sense of duty and diligence exhibited in the Auxiliary. A filing cabinet was purchased by Mrs. Slaughter and placed in the Sellers Auditorium in Jacksonville as a permanent repository for state auxiliary records in accordance with the national historian's suggestion.

Our state auxiliary magazine, *Medaux,* under the able administration of Mrs. Nelson Murray with the aid of her committee and the participation of county "sparks" grew into a representative publication of eight pages. The "picture edition" contained prints of the state executive group, county presidents, the president of the Florida Medical Association and the five members of the

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Medical Auxiliary Advisory Committee, with explanation of the duties of each as well as the attendant obligations toward the annual state meeting which program was published in full detail. Over fifteen hundred reprints furnished by the Florida Medical Journal were enclosed in the last issue outlining "Certain Policies and Procedures" preferred by the Association. Four issues were published during the year making a total of 7,800 copies mailed at a cost of $486.49.

On the county level, progress was first indicated by the promptness of compliance with requests, each keeping in step with State by appointing new chairmen as State made its appointees. Civil defense and study group chairmen were added this year.

The establishment of study groups, learning the nature of the organization, as well as parliamentary law classes to better govern themselves became wide-spread.

Pride in membership created interest for new members resulting in larger attendance at all meetings.

Projects such as civil defense; nurse recruitment; rural health; aiding handicapped children; blood bank; scholarship funds; sponsoring of essay contests in schools; as well as voting to contribute $50 to the Jane Todd Memorial Loan Fund sponsored by the Southern Medical Auxiliary and which aids a doctor who might need the funds to help specialize in gynecology.

In offering active volunteer service to the associations of the blind, the crippled, the heart drive, the diabetic, the tubercular, the Red Cross, the cancer drive, the indigent and the infirm, the beautification of hospitals, comfort offered to the convalescent aged, cheer and diversion taken into orphanages, the doctors' wives, through their membership in the Auxiliary and in these good works, places the organization in a position of dignity in the community.

This education of one's self and others; civic responsibility and philanthropy is the yield of this year's Auxiliary crop in Florida.

The nature of the work in this field is indicative that we have advanced beyond the initial challenge of merely promoting good will among each other to a higher plane which is the resultant of meeting that challenge effectively enough to find pleasure in working and achieving together.

Because one cannot handle the blossoms of a field without carrying away some of their fragrance I am indebted to the national, state and county auxiliaries for the enrichment added to my life through my association with their members. In proportion as our own mind is enlarged we develop a deeper appreciation of people. For the privilege of having served you, I thank you.

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Exhibit "D"
Medical Postgraduate Course Committee-X

March 21, 1951 Through March 20, 1952

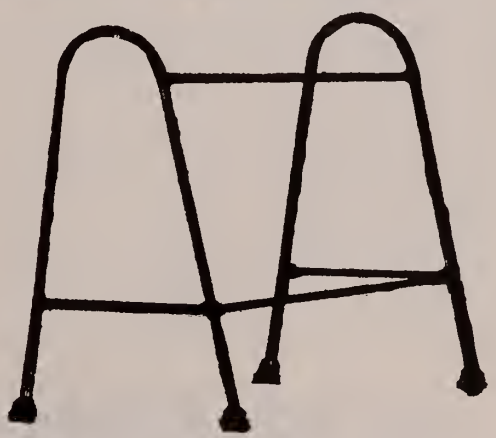
Receipts

Cash as per Last Audit	$1,021.58
Registration Fees, Etc. — 1951 Postgraduate Course	2,605.00
TO BE ACCOUNTED FOR	$3,626.58

Disbursements

Dr. T. Z. Cason, Chairman — Expenses	1,800.00
BALANCE IN BANK — March 20, 1952	$1,826.58

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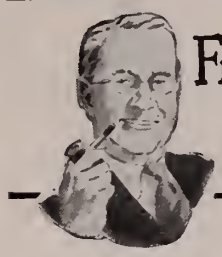
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Advertisement



From where I sit
by Joe Marsh

Well, What Do You Know?

Do you believe in a bunch of old tales about lightning—about how it's attracted by cats or the warmth of cattle . . . how it never strikes in the same place twice . . . or how it's liable to turn milk sour? Lots of people often do—but they're wrong.

Dad Hawkins inspired this column for me today. He's really studied up on lightning since his own cow barn was struck that time.

"Trouble is, most of us don't know half enough about the subject," Dad says. "And about half of what we *do* know about lightning is false!"

From where I sit, Dad's statement applies to a lot of things besides lightning. Too many people think they *know what's best for the other fellow. Like those who would tell a man how to practice his profession . . . or those who resent our right to enjoy a friendly glass of beer if and when we choose. Opinions based on misinformation and prejudice, instead of being "grounded" on true facts can cause more damage than lightning ever did.*

Joe Marsh

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Cook County Graduate School of Medicine

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GYNECOLOGY—Intensive Course, Two Weeks, starting June 16. Vaginal Approach to Pelvic Surgery, One Week, starting September 22, November 3.

OBSTETRICS—Intensive Course, Two Weeks, starting September 29, November 3.

PEDIATRICS—Informal Clinical Course every two weeks.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting July 14. Hematology, One Week, starting June 16. Gastroscopy & Gastroenterology, One Week Advanced Course, June 23.

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When the patient's food intake is inadequate to supply essential nutrients in proper amounts, clinical experience has demonstrated the supportive value of a dietary supplement providing substantial quantities of virtually all needed nutrients—protein, vitamins, minerals, carbohydrate, and fat. The choice of the supplement prescribed, to a large extent, can determine the efficacy of the supplemented diet since over-all nutrient adequacy is the primary aim.

It is apparent from the data shown below that Ovaltine in milk can serve well in markedly increasing the intake of virtually all known nutrients. Taken daily during periods of inadequate consumption of other foods, it offers an excellent means for preventing subclinical nutritional deficiencies which can undermine general health or retard recovery from illness.

The appealing flavor of Ovaltine makes it acceptable to children as well as adults, including the aged. Ovaltine in milk is easily digested, an important feature when digestive disturbances are a factor.

Patients have the choice of either Plain or Chocolate Flavored Ovaltine, both of which are similar in their wealth of nutrients.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three Servings of Ovaltine in Milk Recommended for Daily Use Provide the Following Amounts of Nutrients

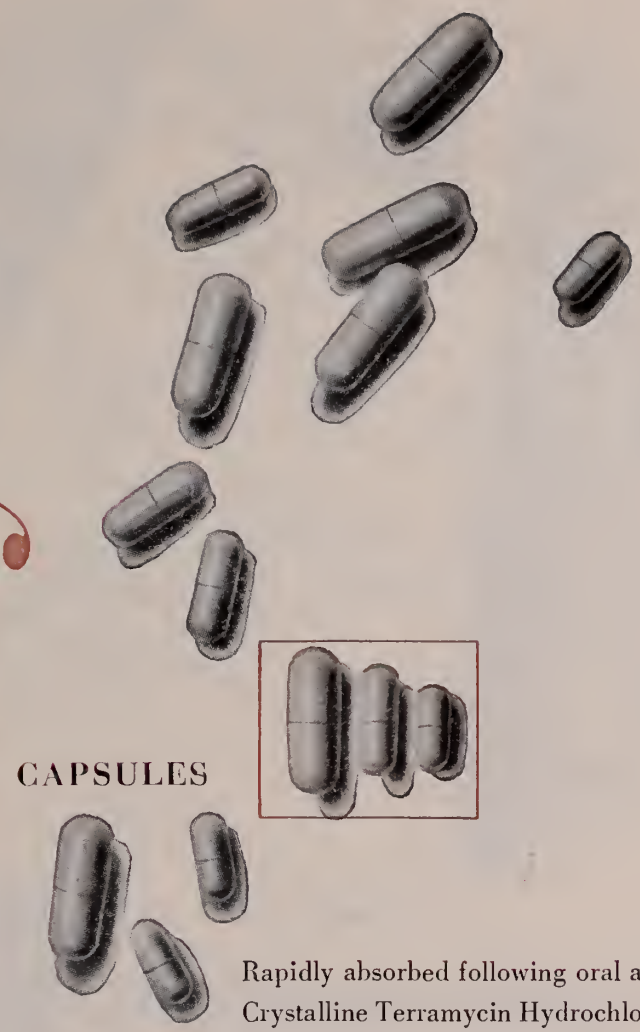
(Each serving made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk)

MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
CHLORINE	900 mg.	BIOTIN	0.03 mg.
COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

Terramycin



CAPSULES

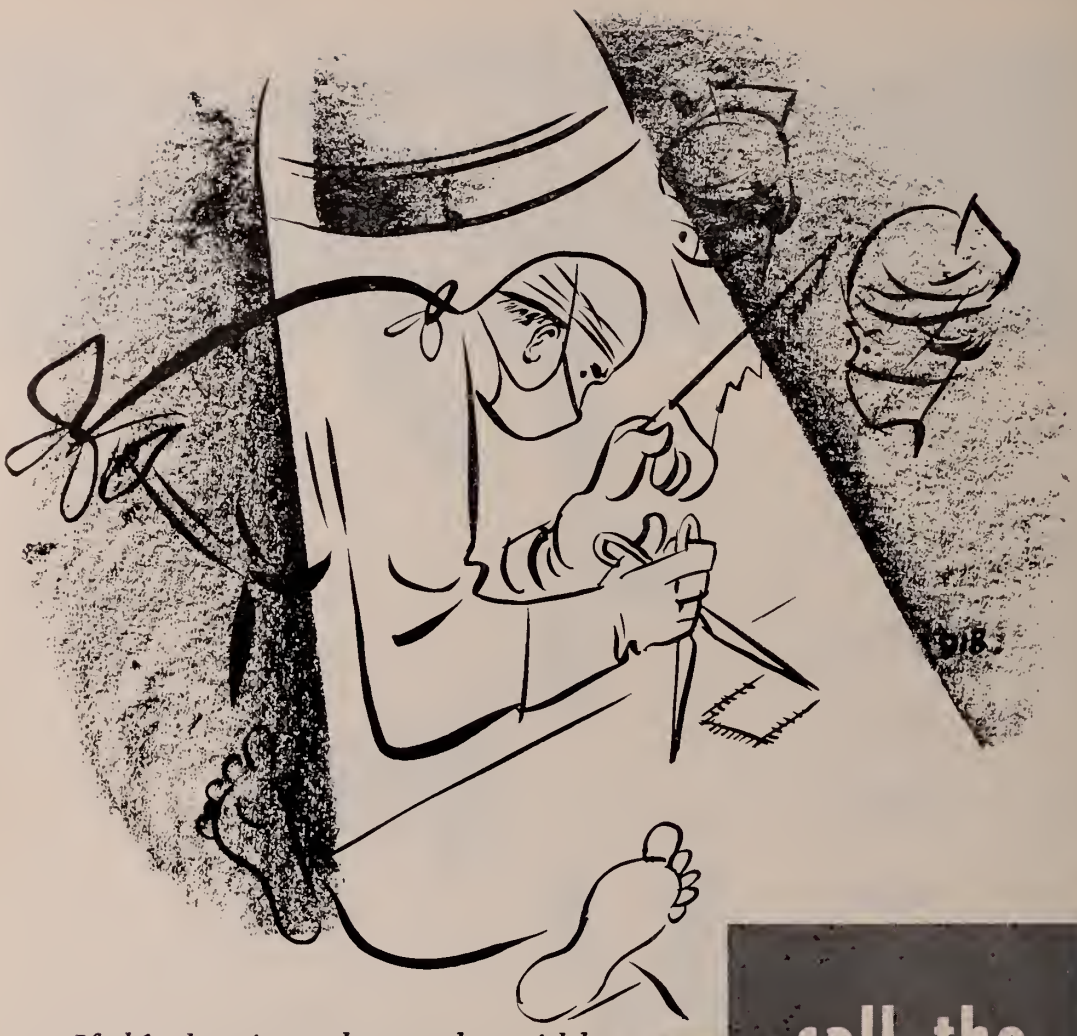
Rapidly absorbed following oral administration, Crystalline Terramycin Hydrochloride Capsules elicit prompt therapeutic response in acute and chronic infections involving a wide range of organs, systems and tissues. Its broad spectrum of antimicrobial activity encompasses organisms of the bacterial and rickettsial as well as certain spirochetal, viral and protozoan groups.

Supplied: 250 mg., bottles of 16 and 100;
100 mg., bottles of 25 and 100;
50 mg., bottles of 25 and 100.

Terramycin is also available as:

Elixir, Oral Drops, Intravenous,
Ophthalmic Ointment, Ophthalmic Solution.

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Southwest	1260 S. W. 22nd Street	Tampa	228 Cass Street Arcade Building
Little River	8340 N.E. Second Ave., Suite 245	Sarasota	237 Main Street, Room 15
Coral Gables	3028 Biscayne Blvd.	Fort Pierce	Florida Bank Building, Room 34
Miami Beach	3028 Biscayne Blvd.	Daytona Beach	116½ Orange Avenue
St. Petersburg	509 White Building	Tallahassee	429 Centennial Building
Lakeland	206 Marble Arcade	Panama City	142 Harrison Avenue
West Palm Beach	305 Citizens Building	Pensacola	501 Theisen Building
Orlando	209 Slayton Building		

For Summer weather convenience . . .

If refrigeration is not available . . .

When mother and baby are traveling . . .



Many doctors prescribe

Baker's Modified Milk

POWDER FORM



Made from Grade A Milk (U.S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with vegetable and animal fats and by the addition of carbohydrates, vitamins and iron.

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*When fed in normal quantities, provides amounts of proteins, vitamins (except C), minerals and essential unsaturated fatty acids equal to or exceeding the daily recommended allowances of The Food and Nutrition Board of the National Research Council.

THE heat of summer is here. Now, more than at any other time of year, Baker's Modified Milk, *powder form*, offers opportunities for successful infant feeding under adverse conditions.

If refrigeration is not available in the home, or when mother and baby are traveling, Baker's Modified Milk *powder* is safe, easily dissolved and easy to use.

In the home, sufficient powder for each feeding may be measured into capped, clean, dry, sterile nursing bottles and warm, boiled water added at feeding time. When traveling, the bottles may be prepared at home, and the boiled water carried in a thermos bottle.

For the comfort of both mother and baby in hot weather traveling, we suggest that you specify Baker's Modified Milk, *powder form*.

Baker's Modified Milk is also available in liquid form. When diluted to normal strength, both powder and liquid have the same analysis and both provide the same nutritionally adequate* formula.

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ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Florida Medical Association	Robert B. McIver, Jacksonville	Samuel M. Day, Jacksonville	Hollywood, Apr. 26-29, '53
Florida Medical Districts	Eugene G. Peek, Jr., Ocala	Council Chairman	
A-Northwest	Francis M. Watson, Marianna	Benjamin A. Wilkinson, Tallahassee	Panama City, 1952
B-Northeast	William C. Thomas, Jr., Gainesville	Eugene L. Jewett, Orlando	Daytona Beach, 1952
C-Southwest	Emmett E. Martin, Haines City	Hugh G. Reaves, Sarasota	St. Petersburg, 1952
D-Southeast	Erasmus B. Hardee, Vero Beach	Donald W. Smith, Miami	Ft. Pierce, 1952
Florida Specialty Societies			
Academy of General Practice	Edward F. Shaver, Tampa	Frank T. Linz, Tampa	Hollywood, Apr. 26, '53
Allergy Society	Nelson Zivitz, Miami Beach	Solomon D. Klotz, Orlando	" "
Anesthesiologists, Soc. of	John T. Stage, Jacksonville	Breckenridge W. Wing, Orlando	" "
Chapter, Am. Coll. Chest Phys	Alexander Libow, Miami Beach	DeWitt C. Daughtry, Miami	" "
Derm. and Syph., Soc. of	Lewis Capland, Miami Beach	Morris Waisman, Tampa	" "
Health Officers' Society	George W. Edwards, II, Orlando	Lorenzo L. Parks, Jacksonville	" "
Heart Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
Industrial & Railway Surgeons	Julius C. Davis, Quincy	John H. Mitchell, Jacksonville	Hollywood, Apr. 26, '53
Neurology & Psychiatry	Samuel G. Hibbs, Tampa	William H. McCullagh, Jacksonville	" "
Ob. and Gynec. Society	Dorothy D. Brame, Orlando	J. Champneys Taylor, Jacksonville	" "
Ophthal & Otol., Soc. of	Joseph W. Taylor, Sr., Tampa	Carl S. McLemore, Orlando	" "
Orthopedic Society	Arthur H. Weiland, Coral Gables	Edward W. Cullipher, Miami	" "
Pathologists, Society of	Robert J. Poppiti, Miami Beach	Alfred E. Cronkite, Fort Lauderdale	" "
Pediatric Society	Egbert V. Anderson, Pensacola	J. K. David, Jr., Jacksonville	" "
Proctologic Society	Alex. E. Rosenberg, Miami Bch	George Williams, Jr., Miami	" "
Radiological Society	Thomas H. Lipscomb, Jacksonville	A. Judson Graves, Jacksonville	" "
Urological Society	George H. Putnam, Gainesville	David W. Goddard, Daytona Beach	" "
Florida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 7, '52
Blood Banks, Association	Horace A. Day, Orlando	Russell V. Douglas, Orlando	
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Daytona Beach, Nov. 16, '52
Blue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Herbert E. White, St. Augustine	Hollywood, Apr. 26, '53
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
Dental Society, State	W. G. McLeod, D.D.S., Pensacola	Coleman Brown, D.D.S., Tampa	St. Petersburg, Apr. 20-23, '53
Hospital Association	Mother Loretto Mary, Tampa	Tracy B. Hare, Miami	Daytona Beach, Nov. '52
Medical Examining Board	Bricey M. Rhodes, Tallahassee	Homer L. Pearson, Jr., Miami	Jacksonville, June 29-July 1, '52
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, June 23-28, '52
Nurses Association, State	Miss Undine Sams, Miami	Bertha King, Tampa	St. Petersburg, Nov. 14-16, '52
Pharmaceutical Association, State	Mr. Clyde Morris, Daytona Beach	Mr. R. Q. Richards, Ft. Myers	St. Petersburg, May, '53
Public Health Association	Mrs. May Pynchon, Jacksonville	Mr. Fred B. Ragland, Jacksonville	Jacksonville, Oct., '52
Tuberculosis & Health Assn.	Mr. Walter McJordan, Orlando	Mrs. Elsa B. Conant, Pt. St. Joe	
Woman's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 26-28, '53
American Medical Association	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Chicago, June 9-13, '52
A.M.A. Clinical Session	John W. Cline, San Francisco	Geo. F. Lull, Chicago	Denver, Dec. 2-5, '52
Southern Medical Association	R. J. Wilkinson, Huntington, W. Va	Mr. C. P. Loranz, Birmingham	Miami, Nov. 10-13, '52
Alabama Medical Association	B. W. McNease, Fayette	Douglas L. Cannon, Montgomery	Birmingham, Apr. 16-18, '53
Georgia, Medical Assn. of	W. F. Reavis, Waycross	David Henry Poer, Atlanta	
S. E. Hospital Conference	Mr. Norman Losh, Orlando	Mr. D. O. McClusky, Tuscal'sa, Ala.	New Orleans, April 8-10, '53
Southeastern Allergy Assn.	L. C. Todd, Charlotte, N. C.	Kath. B. MacInnis, Columbia, S. C.	
Southeastern, Am. Urological Assn.	William Miner, Covington, Ky.	Sidney Smith, Raleigh, N. C.	Havana, Cuba, Mar. 26-29, '53
Southeastern Surgical Congress	H. L. Claud, Washington, D. C.	B. T. Beasley, Atlanta	Louisville, Mar. 9-12, '53
Gulf Coast Clinical Society	Alvin L. Stebbins, Pensacola	Dale E. York, Pensacola	Pensacola, Oct. 16-17, '52

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Janet's Nursery for Babies

VENICE, FLORIDA

A Nursery for Handicapped Babies

For Information write

JANET'S NURSERY

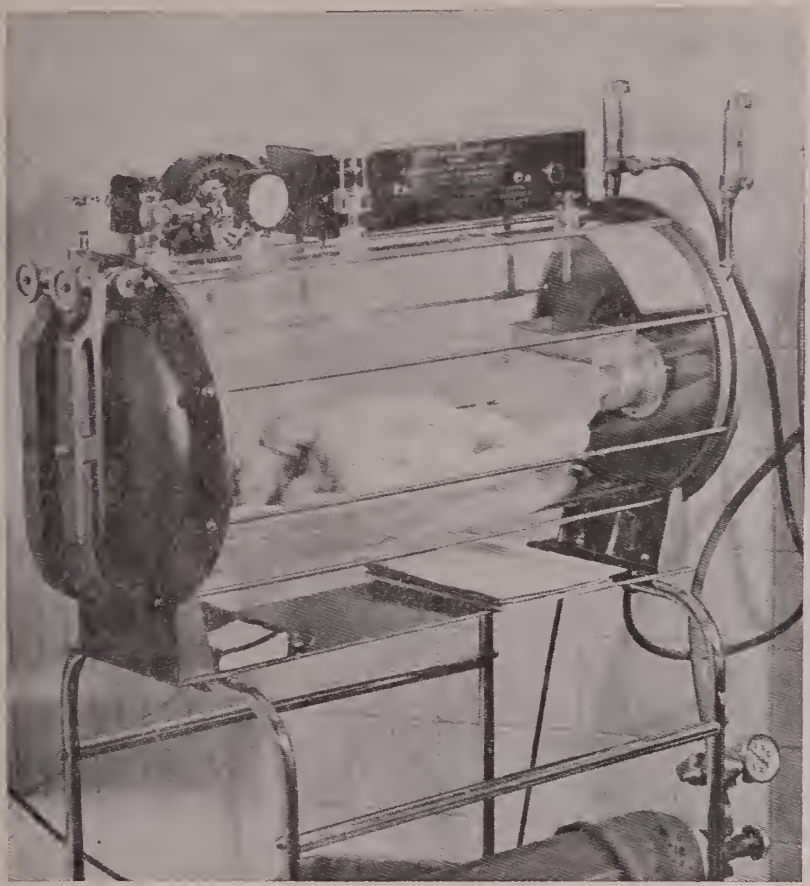
Venice, Florida

	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS Total	MEMBERS Paid	COUNCILOR
A	Bay	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	William F. Humphreys, Jr., M.D. 112 E. 3rd Court Panama City		24	21	
	Escambia *Santa Rosa*	Chas. J. Heinberg, M.D. 109 N. Baylen St. Pensacola	Raymond B. Squires, M.D. 386 Brent Bldg. Pensacola	2nd Tuesday 8:00 P.M.	75	67	
	Franklin-Gulf	John W. Hendrix, M.D. Port St. Joe	William P. Blackmon, M.D. Apalachicola	Last Wednesday	8	7	
	Jackson-Calhoun	Albert E. McQuagge, M.D. 207 N. Green St. Marianna	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	17	14	A-1-54 Francis M. Watson, M.D. Marianna
	Walton-Okaloosa	William D. Cawthon, M.D. DeFuniak Springs	Edgar H. Myers, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	16	15	
	Washington-Holmes	George W. Carter, M.D. Chipley	Bayllye W. Dalton, M.D. Chipley		6	100%	
	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	12	
	Leon-Gadsden- Liberty-Wakulla- Jefferson	Ernest W. Ekermeyer, M.D. 516 N. Adams St. Tallahassee	George H. Massey, M.D. 204 N. Madison St. Quincy	Quarterly 7:30 P.M.	59	53	
	Suwannee	Edward G. Haskell, Jr., M.D. Branford	J. Dillard Workman, M.D. R.F.D. 2, Box 40 Live Oak	1st Saturday 9:30 A.M.	9	100%	A-2-53 Benjamin A. Wilkinson, M.D. Tallahassee
	Madison	A. Franklin Harrison, M.D. Madison	Eugene D. Thorpe, M.D. Madison		4	3	
	Taylor *Dixie, Lafayette*	Walter J. Baker, M.D. Foley	Ralph J. Greene, M.D. Perry	Last Friday 8:00 P.M.	4	1	236
B	Alachua *Bradford, Gilchrist, Union*	Henry J. Babers, Jr., M.D. Box 709 Gainesville	Raymond S. Camp, M.D. 907 S. W. 4th Ave. Gainesville	2nd Tuesday 8:00 P.M.	49	47	
	Duval *Clay*	Ferdinand Richards, M.D. 508 Greenleaf Bldg. Jacksonville	Joseph A. J. Farrington, M.D. 415 Greenleaf Bldg. Jacksonville	1st Tuesday 8:15 P.M.	253	215	
	Marion *Levy*	Carl S. Lytle, M.D. 1206 E. Ocklawaha Ave. Ocala	Bertrand F. Drake, M.D. Professional Bldg. Ocala	3rd Tuesday 7:00 P.M.	29	21	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Nassau	David G. Humphreys, M.D. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	10	9	
	Putnam	Lawrence G. Hebel, M.D. 119 N. 4th St. Palatka	Bennie J. Massey, M.D. Box 105 Palatka	2nd Tuesday 6:00 P.M.	11	10	
	St. Johns	Charles C. Grace, M.D. 145 King St. St. Augustine	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	James A. Sewell, M.D. 430 New Haven Ave. Melbourne	Theodore J. Kaminski, M.D. Box 576 Melbourne	2nd Tuesday	23	21	
	Lake *Sumter*	Robert H. Montgomery, M.D. Mount Dora	J. Basil Hall, M.D. Mount Dora	1st Wednesday 7:30 P.M.	26	23	
	Orange *Osceola*	Carl S. McLemore, M.D. 1217 Kuhl Ave. Orlando	James B. Glanton, M.D. 1300 Kuhl Ave. Orlando	3rd Wednesday 8:00 P.M.	154	138	B-4-53 Eugene L. Jewett, M.D. Orlando
	Seminole	Julian N. Tolar, M.D. First Street Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	16	100%	
	Volusia *Flagler*	J. Richard West, M.D. 224 S. Palmetto Ave. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	81	76	667
C	Hillsborough	Sherman B. Forbes, M.D. 409 Citizens Bldg. Tampa	James N. Patterson, M.D. 911 Citizens Bldg. Tampa	1st Tuesday 8:00 P.M.	174	153	
	Manatee	John E. Granade, M.D. 114 Walcaid Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	19	16	
	Pasco-Hernando- Citrus	William H. Walters, Jr., M.D. Lacoochee	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	17	16	C-5-53 Hugh G. Reaves, M.D. Sarasota
	Pinellas	John P. Rowell, M.D. 2500 Driftwood Rd., S. E. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:30 P.M.	190	182	
	Sarasota	Henry G. Morton, M.D. 555 Golf St. Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	2nd Tuesday 8:30 P.M.	44	100%	
	DeSoto-Hardee- Highlands- Glades	Harold S. Agnew, M.D. 705 E. Oak St. Arcadia	Charles H. Kirkpatrick, M.D. Box 389 Arcadia	2nd Tuesday 8:00 P.M.	27	23	
	Lee-Charlotte- Collier-Hendry	John S. Stewart, M.D. Lee Memorial Hosp. Fort Myers	Harvie J. Stipe, M.D. 210 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	24	23	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Ivan W. Gessler, M.D. 402 Professional Bldg. Winter Haven	Jere W. Annis, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	91	79	586
D	Indian River	P. T. McClellan, M.D. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	7	5	
	Palm Beach	Cecil M. Peek, M.D. 535 S. Flagler Drive West Palm Beach	David A. Newman, M.D. 511 Citizens Bldg. West Palm Beach	3rd Monday 8:00 P.M.	117	113	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie- Okeechobee- Martin	Richard F. Sinnott, M.D. 209 Koblegard Bldg. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	15	10	
	Broward	Lloyd U. Lumpkin, M.D. 918 E. Las Olas Blvd. Ft. Lauderdale	William K. Peck, M.D. 915 N. E. 2nd St. Ft. Lauderdale	4th Tuesday 8:00 P.M.	84	72	
	Dade	Ralph S. Sappenfield, M.D. 630 duPont Bldg. Miami	Nelson Zivitz, M.D. 311 Lincoln Rd. Miami Beach	1st Tuesday 8:30 P.M.	599	477	D-8-53 Donald W. Smith, M.D. Miami
	Monroe	James B. Parramore, M.D. Box 326 Key West	Herman K. Moore, M.D. 600 Elizabeth St. Key West	2nd Thursday 8:00 P.M.	12	11	834

*Supervise and aid until organized separately.

Total 2,323

WHAT'S ABSOLUTELY NEW?



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IMMEDIATE INFANT SURVIVAL

It would seem that . . . this observer must comment most favorably upon the new infant respirator devised by Bloxsom called the "positive-pressure air lock."

Bloxsom . . . has devised a positive air lock mechanism which repeats the cycles of pressures and timing found within the uterus itself. . . .

Speaking after a period of careful and critical observation, the writer has developed a peace of mind about the newborn infant which is most grateful. All infants are placed routinely within the air lock after delivery — . . . No efforts are made to resuscitate the infant as such but instead it is quickly transferred from mother to mechanical mother. . . . Some infants may stay in the air lock a period of only a few minutes and then may be removed to the regular neonatal nursery. Other infants may stay a matter of some days with complete security. Bloxsom's preliminary figures on the increased survival of premature infants have been most encouraging. . . . We cannot help but comment on what to us seems to be a definite improvement in the neonatal life period of our future citizens.

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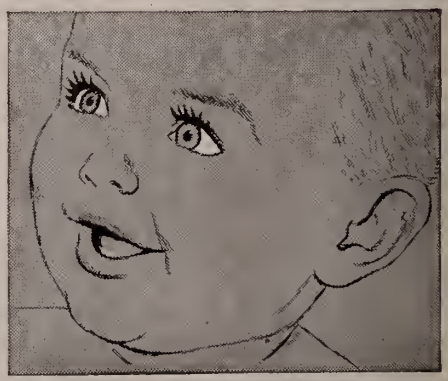


A 1:1 dilution supplies 20 calories per fluid ounce

Mothers appreciate Lactum's convenience. Feedings are prepared simply by adding water. The 1 to 1 dilution of Lactum and water (volume for volume) eliminates complicated measurements.

Infants thrive on Lactum. Clinical observations* report infants fed Lactum show good tolerance of feedings, low incidence of digestive disturbances and infections, satisfactory growth response, and a generally "excellent" picture of health and development.

*Frost, L. H., and Jackson, R. L.: Growth and Development of Infants Receiving a Proprietary Preparation of Evaporated Milk with Dextri-Maltose and Vitamin D, J. Pediat. 39:585-592 (Nov.) 1951.



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